

ASOTIN COUNTY PUD

Supplementary Plan Description

CONTENTS

Eligibility and Participation	2
DEPENDENT COVERAGE	3
Generally Excluded Charges.....	9
Coverage Termination	12
Birthing Center – An institution that meets all of the following requirements;	13
Physician Benefits.....	21
General “Questions and Answers” About this Benefit.....	23
Eligibility	24
Benefit Cost	25
Coinsurance Limit.....	26
In-patient Hospital	26
Convalescent Nursing Home Care.....	27
Eligible Surgical Expenses	27
Outpatient Surgical Expenses (Excludes office setting).....	28
Mental Health and Substance Abuse Benefits	29
Diagnostic X-ray and Laboratory Expenses	29
Supplemental Accident Expenses	30
Pregnancy Benefits	30
Annual Physical Examination Expenses.....	31
Alternative Medicine	31
Other Medical Expenses	32
Home Health Care Expense Benefit	33
Hospice Care Expense Benefit.....	34
Major Medical Expense Benefit Exclusions.....	35
VISION CARE EXPENSE BENEFIT	36
Vision Care Expense Benefit Amounts.....	37
Eligibility	38
WEEKLY SHORT TERM DISABILITY BENEFIT PLAN	39
Schedule of Benefits	39
Length of Weekly Short Term Disability Benefits.....	40
DENTAL EXPENSE BENEFIT.....	41
How To File A Claim – All Claims	52

APPEAL OF A CLAIM DENIAL – ALL CLAIMS.....	54
CUSTOMER SERVICE DIRECTORY	54

Eligibility and Participation

Who is an eligible employee?

An eligible employee is an employee who:

- Is not excluded by job classification and
- Anticipates working at least 1,000 hours within their first 12 months of employment;
- Has worked at least 1,000 hours within subsequent calendar years;

Once an employee works 1,000 hours his or her first year of employment or during subsequent calendar years and continues to work 1,000 hours, he or she is eligible for coverage by group benefits.

When will I be able to file a claim under a benefit for which I'm eligible?

Your coverage under a benefit is effective when you have satisfied your employer's eligibility waiting period; are otherwise eligible to participate in the benefit; and have signed and completed the "Enrollment for Participation in Retirement & Insurance Programs." There is specific information on the eligibility waiting period and other eligibility requirements within the SPD under each plan-of-benefits.

Can I cover my dependents under these benefits?

In some cases, yes. An employee's dependents are eligible for coverage under some of the benefits if they are "eligible dependents." Read the **Eligibility** section of the applicable benefit to determine if dependents are eligible.

Can my benefits be changed or terminated?

The Administrator may amend, modify, change, revise, discontinue or terminate the Plan at any time.

A participant's and his or her dependent coverage can terminate on the earliest of:

- The day the participant terminates employment,
- The date the participant ceases to be in an eligible class of employees,
- The day the participant fails to make any required contributions to the Plan, or
- The day the participant's employer discontinues the Plan.

If coverage is due to terminate because of the participant's death, coverage for dependents will continue until the earliest of:

- The day required contributions are not made,
- The day the dependent no longer qualifies as a dependent except as provided by law, or
- The day the surviving spouse remarries or dies except as provided by law.

A dependent's coverage can terminate on the day the dependent no longer qualifies as an eligible dependent. A dependent that is physically or mentally incapable of self-support may continue coverage during the period the dependent remains incapacitated and unmarried as long as:

- The dependent continues to be covered by the Plan,
- Proof of incapacity is received within 31 days after coverage would otherwise terminate and at any other time required, and
- The dependent's condition of incapacity is approved by PURMS.

NOTE: Your rights to postretirement benefits are subject to the policies of your employer and can change at any time.

DEPENDENT COVERAGE

Who are “eligible dependents”?

Generally, your spouse and children are considered your dependents. To be “eligible dependents,” however, they must satisfy the following definitions. Additional detailed information can be obtained from your Benefits Administrator.

- Your legal spouse. “Spouse” includes a common-law spouse where application for consideration has been submitted and approved;
- Your legal children under age 26 and are not eligible for employer-based health benefits other than through their parents.
- Disabled children who are totally incapacitated and incapable of self-support if application is made and approved by PURMS;
- Any unmarried children meeting the same age restrictions given above and who live with you in a child-parent relationship are eligible if PURMS has approved your request to cover them. Employees who adopt children, have children placed for adoption, have responsibility for step-children, or have court appointed legal guardianship over children, may include them for dependent coverage provided the employees meet certain criteria and conditions. You must provide additional information on a special form when requesting coverage for these children. Ask your Benefits Administrator for the form.
- Your ex-spouse can be approved for more than 36 months of medical, vision, and/or dental COBRA continuation coverage if:
 - The divorce decree requires you to provide the coverage for more than the 36 months required by COBRA and these documents are submitted to PURMS;
 - Your coverage continues in effect;
 - Your employer continues to provide the coverage through PURMS; and
 - You continue to pay the required premium. (Refer to the COBRA section for more information.)
- No one will be eligible as a dependent while in military service.

Are children who are disabled or incapable of caring for themselves allowed to continue to be covered by the Plan even though they reach the maximum age under the Plan?

Yes. Coverage may be continued while remaining disabled and unmarried, if your own coverage continues **in effect**. To continue a child under this provision, you must provide proof of incapacity satisfactory to PURMS within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

Is it necessary that I notify you when my dependent(s) become eligible for coverage, or when I no longer have eligible dependents?

Yes, once you are in the benefit plan, it is necessary that you notify us promptly if:

- You are currently enrolled in coverage only for yourself and you want to add one or more dependents;
- You currently have dependent coverage and all of your dependents are no longer eligible;
- You currently have dependent coverage and you want to drop all dependent coverage.

How do I add dependents to my coverage?

- If you have effective single coverage when you gain a dependent through marriage birth, adoption, or court action, the dependent is eligible for coverage without benefit limitations if you request their dependent coverage anytime prior to an within 31 days following the occurrence.
- If your request is dated prior to the date of the occurrence, their dependent coverage will be effective on the date of the occurrence.
- If you waited until after the occurrence to make the request, their coverage will be effective on the date of the request, subject to the limitations described in the next question and answer.

What happens if I don't report my dependent(s) within 31 days after my dependent(s) become eligible?

- **Medical Coverage**

If your request for medical coverage is dated more than 31 days after the occurrence, your dependent(s) will be considered late enrollee(s) and they will be subject to an 18-month preexisting condition exclusion period. You should submit a Certificate of Coverage to prove any prior coverage history in order to decrease the preexisting condition exclusion period by the amount of any creditable coverage. Refer to **The Health Insurance Portability and Accountability Act (HIPAA)** section for more information.

- **Dental Coverage**

If your request for dental coverage is dated more than 31 days after the occurrence, your dependent(s) will be considered late enrollee(s). During the first year coverage is in effect, they will be limited only to dental services made necessary by an accident occurring while the individual was covered and to "basic" dental services. In addition, if your dental plan includes orthodontic coverage, orthodontic coverage will not apply for two years to a procedure for which an active appliance is installed before a late enrollee's covered. Refer to the ElectREdent Dental Expense Benefit section for more information.

- **Vision Coverage**

If you request for vision coverage is dated more than 31 days after the occurrence, your dependent(s) will be considered late enrollee(s) and they will be limited to eye exams only for the first year of coverage. Refer to the Vision Care Expense Benefit section for more information.

What happens if, when my child is born, I am carrying coverage for myself but not for dependents?

The Newborn Child Provision will apply. This provision assures you that your newborn child will be covered at birth for health care benefits. However, you should report your newborn child for coverage within the 31-day period following birth otherwise your child's coverage will terminate at the end of that 31-day period.

What happens when my spouse and I both are eligible for PURMS sponsored medical, vision and/or dental plans?

Under the PURMS sponsored medical, vision and/or dental coverage, no one may be both a covered employee and an eligible dependent. A child cannot be an eligible dependent of more than one employee.

If you and your spouse are both employed and are otherwise eligible for coverage in PURMS sponsored medical, vision and/or dental benefits, these eligibility rules apply:

- When no other dependents are covered, you each will be covered as employees.
- When other dependents are covered, either the husband or the wife may be covered as an employee and the remaining spouse covered as a dependent.

If the spouse who is insured as the employee terminates employment, the other spouse may enroll as the employee and provide coverage for

other previously insured dependents.

Coordination with other Medical, Vision and Dental Plans

Do PURMS' medical, vision, and dental benefits coordinate with other plans?

This Plan contains a non-profit provision coordinating it with other similar plans under which an individual is covered, so that the total benefits available will not exceed 100% of the allowable expenses. "Similar plans" means health plan (medical, vision and dental) benefits provided by:

- Group insurance or other coverage for a group of individuals;
- Coverage under governmental programs (except Medicare) or required by statute (including no fault coverage to the extent required by a motor vehicle insurance statute).

What is an allowable expense?

An "allowable expense" is any necessary, reasonable and customary expense covered, at least in part, by one of the plans of the same type (medical, vision or dental).

How does the coordination work between primary and secondary plans?

When a claim is made, the **primary** plan pays its benefits without regard to any other plans. The **secondary** plans adjust their benefits so that the total benefits available will not exceed the allowable expenses. No plan pays more than it would without the coordination provision.

What are the rules if all plans have a coordinating provision?

A plan without a coordinating provision similar to ours is always the primary plan. If all plans have such a provision, the following rules apply:

- 1) Employee/dependent: The plan covering an individual as an employee is primary to the plan covering an individual as a dependent.
- 2) Dependent child/parents not separated or divorced: The plan of the parent whose birthday falls earlier in the year will be primary. (If both parents have the same birthday, the plan that has covered one of the parents the longer is primary.
- 3) Dependent child/parents separated or divorced: The plans of the parents pay in this ordered:
 - a) If a court decree has established financial responsibility for the child's health care expenses the plan of the parent with this responsibility;
 - b) The plan of the parent with custody of the child;
 - c) The plan of the stepparent married to the parent with custody of the child;
 - d) The plan of the parent not having custody of the child.
- 4) Active/inactive: The plan covering an individual employee through active employment is primary to the plan covering the individual through retirement or layoff status.
- 5) Longer/shorter length of coverage: IF 1,2,3 or 4 above do not apply, the plan covering the individual the longest period is primary.

What happens when the Plan is the secondary plan?

When your plan is the secondary plan and its payment is reduced because of the primary plan's benefits, a record is kept of the reduction. This amount will be used to increase your plan's payments on the patient's later claims in the same calendar year – to the extent there are allowable expenses that would not otherwise be fully paid by your plan and the others.

Modify Health Care Benefits for Persons Eligible For U.S. Medicare

When Medicare is the primary payer, this Plan determines its normal benefits on eligible charges then subtracts what Medicare has paid. If your provider of service accepts Medicare assignment, then any charges exceeding Medicare's approved amount are not eligible for benefits. Benefits for eligible expenses are reduced by the Medicare benefits available under Part A and Part B.

The Administrator can provide you with specific information on how Medicare affects your benefits.

The Health Insurance Portability and Accountability Act (HIPAA)

What are The Health Insurance Portability and Accountability Act?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) establishes new administrative procedures to give employees the information they need to establish medical plan coverage history if they lose their health insurance. Once an employee is covered by a health plan, coverage must be tracked for inclusion on a certificate of Coverage. This Certificate of Coverage must then be given to an individual who loses coverage under any health plan.

Why do I need a Certificate of Coverage/

If you lose your health insurance and then become covered under a new health plan, HIPAA limits the length of time that the new plan can impose preexisting condition restrictions. A new employee may not be subject to more than a 12-month preexisting condition limitation (18 months for late enrollment). Under HIPAA, a new health plan must give you credit for the length of time that you had previous continuous health covers. If you already had 12 months of continuous health coverage (without a break in coverage of 63 days or more), you will not be subject to a 12-month exclusion for any preexisting conditions. A Certificate of Coverage proves your history of creditable coverage.

What is creditable coverage?

Most health coverage is considered "creditable" coverage. Creditable coverage is coverage under almost any type of medical plan, such as a group health plan (including COBRA continuation coverage), HMO, individual health insurance policy, Medicaid or Medicare.

When is a Certificate of Coverage issued?

A certificate of Coverage must be provided to any person covered under a health plan when an individual:

- Loses coverage under the plan,
- Loses COBRA continuation coverage, or
- Requests it, within 24 months after coverage under the plan ends.

What is a preexisting condition?

Under HIPAA, a preexisting condition is a condition for which medical advice, diagnosis, care or treatment was received or recommended within the 6-month period ending on your enrollment date. Pregnancy cannot be treated as a preexisting condition. Preexisting conditions may not be applied to newborns or adopted children covered within 31 days of birth, adoption, or placement for adoption, as long as the child does not incur a break in coverage of 63 days or more.

What happens if I have a break in health insurance coverage?

Under the break in coverage rule, individuals who are without coverage for at least 63 days lose their right to reduce the period of a new plans' preexisting condition exclusion or limitation. Any coverage occurring prior to a break in coverage of at least 63 days will not be credited against a preexisting condition exclusion period. Waiting periods, which may cause a break in coverage, are not counted toward the 63 days.

What happens if I don't enroll in the medical benefit of this Plan when I first become eligible?

You will be considered a late enrollee and you will be subject to an 18-month preexisting condition exclusion period. You should submit a Certificate of Coverage to prove your prior coverage history in order to decrease the preexisting condition exclusion period by the amount of your creditable coverage.

However, HIPAA established a special enrollment period if you initially declined enrollment of yourself or your dependents (including your spouse) because you were covered by other health insurance and you stated in writing that this was the reason coverage was declined. You will be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth adoption, or placement of adoption, you may be able to enroll yourself and/or your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

COBRA

Can medical, vision and dental benefits be continued if a person is enrolled in these coverages and become ineligible for them?

Yes. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), all employees and their qualified beneficiaries covered under an employer's health plan have the right to elect to temporarily continue their coverage under the plan if it would end due to certain "qualifying events".

Who are "qualified beneficiaries"?

Individuals may be eligible for COBRA coverage as qualified beneficiaries if they are plan participants on the day before a qualifying event occurs. Generally, this applies to you, your spouse and your dependent children. HIPAA expanded the definition of a qualified beneficiary to also include a child born to, or placed for adoption with, the covered employee during the period of COBRA coverage. Individuals who terminate this coverage because they have other coverage are not considered qualified beneficiaries for COBRA.

What are "qualifying events"?

A qualifying event is a specified event that causes you or your covered dependents to lose health coverage. There are several types of qualifying events for employees, their spouses and dependent children.

Qualifying events for an employee are:

- Termination (voluntary or involuntary) of employment for any reason other than gross misconduct;
- Reduction in work hours (below 1,000 that result in loss of coverage; or
- Retirement, if retiree health coverage is not offered by your employer.

Qualifying events for your spouse are:

- Your termination of employment for any reason other than gross misconduct;
- Your reduction in work hours (below 1,000) that result in loss of coverage;
- Divorce;
- Your retirement 2when your employer does not offer retiree health coverage and your spouse is not eligible for Medicare; or
- Your death.

Qualifying events for your dependent children:

- Your termination of employment for any reason other than gross misconduct;
- Your reduction in work hours (below 1,000) that result in loss of coverage;
- Your retirement when your employer does not offer retiree health coverage;
- The loss of a child's dependent status as defined under the terms of this plan; or
- Your death.

When am I responsible for reporting a qualifying event?

You or your spouse must notify your employer within 60 days of a death, divorce, or when a child loses dependent status. Failure to do so will result in the loss of the right to continued coverage.

How long does COBRA last?

An employee, spouse or dependent children are entitled to 18 months of continuous coverage if the qualifying event is due to a termination of employment, reduction in hours, or if your employer does not offer retiree coverage. Any other qualifying event, such as death, divorce, or loss of dependent eligibility, allows the qualified beneficiary 36 months of coverage.

COBRA coverage begins the same date the qualifying event occurs, regardless of when you make your election to continue coverage. If you reject COBRA coverage for yourself and/or any or all of your eligible dependents, you may still elect COBRA coverage if fewer than 61 days have passed between the date of the qualifying event and the date you elect COBRA coverage. In this case, COBRA coverage takes effect on the date you make the election, not the date of the qualifying event.

HIPAA changed the disability extension rules. If a qualified beneficiary is disabled during the first 60 days after the qualifying event occurs, continuation of coverage may be extended for an additional 11 months, for a total of 29 months. To qualify for the disability extension, the individual must:

- Be determined by the Social Security Administration to be disabled within the first 60 days of COBRA coverage, and
- Notify PURMS within 60 days of the Social Security disability determination and before the end of the 18-month COBRA continuation period.

If the individual entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, those non-disabled family members are also entitled to the 29-month disability extension.

If a divorce decree mandates group coverage for an ex-spouse, coverage will be continued past 36 months only if the divorce decree mandates and additional premiums for such coverage are paid.

How much will COBRA coverage cost me?

Any person who elects to continue coverage under the Plan may have to pay the full cost of that coverage (including both the share you now pay, if any, and the share your employer now pays), plus any additional amounts permitted by law. Your payments for continued coverage must be made on the first day of each month, in advance.

When will COBRA continuation coverage terminate?

Qualified beneficiaries lose COBRA coverage if one of the following occurs:

- The premium is not paid within the designated grace period. You are given 45 days from the date continuation coverage was selected to pay all premiums for coverage to date. After the first payment, you have 31 days from the first of each month to pay COBRA premiums;
- Your employer terminates group health coverage for all employees;

- The qualified beneficiary is entitled to Medicare benefits;
- The qualified beneficiary becomes covered under a new health plan with a preexisting condition clause if that clause does not apply to the qualified beneficiary due to the HIPAA rules that reduce the limitation period by prior creditable coverage; or
- You reach the end of the 18-month, 29-month, or 36-month continuation period, whichever applies.

What special death benefits are available to my surviving spouse and dependents if I die?

When a covered employee dies, the surviving spouse and eligible dependent children may continue coverage if the employee's death occurred while the employee was covered by PURMS' medical, vision and/or dental plans and the employee carried dependent coverage. PURMS will waive premiums for up to two years.

The premium waiver will terminate on the earliest of the following:

- Termination of the plan;
- At the end of 24 consecutive months;
- When the surviving spouse remarries; or
- When dependent children lose eligibility.

After the premium waiver ceases, the surviving spouse and dependent children may continue coverage on a premium-paying basis, provided they are otherwise eligible. If they become ineligible for coverage, they may elect COBRA coverage at the time (provided the plan is still in effect). COBRA runs concurrently with the death benefits under this Plan even though COBRA coverage has not previously been elected. The effective date of the COBRA coverage is the date of the employee's death and coverage may be continued for 36 months from that date.

If the surviving spouse remarries during the first 36 months of coverage, coverage will end at 36 months. If the surviving spouse remarries after 36 months, coverage ends on the date of remarriage. If the surviving spouse never remarries, coverage will cease at his or her death. All other dependent coverage will also cease on the date of death. Coverage will automatically terminate if the required premiums are not paid or if the plan terminates.

Family and Medical Leave Act (FMLA)

How does the Family and Medical Leave Act of 1993 (FMLA) affect my benefits?

FMLA requires certain employers to maintain group health insurance for up to 12 weeks of continuous or intermittent unpaid leave each year for specific family and medical reasons. FMLA also contains rules regarding the rights of employees when and if they return from FMLA leave and other issues.

Not all employers are covered by FMLA and not all employees of covered employers are eligible for FMLA rights. The Administrator can provide you with specific information on how FMLA affects your benefits.

Generally Excluded Charges

What charges are generally excluded under this Plan?

The following charges are not covered under this Plan:

- 1) **Occupational injury or disease charges** – charges incurred in connection with:
 - a) injury arising out of, or in the course of, any employment for wage or profit; or

- b) disease covered, with respect to such employment, by any Workers' Compensation law, occupational disease law or similar legislation, except when incurred by an individual proprietor or partner who is covered as an employee and who cannot be covered by Workers' Compensation, or by a dependent who cannot be covered by Workers' Compensation.
- 2) **Government plan charge** – any charge for a service or supply furnished by or on behalf of the United States Government or any other government
- a) unless payment of the charge is required by law;
 - b) for a service or supply to the extent to which any benefit in connection with such a service, supply or charge is provided by any law or governmental program under which the individual is or could be covered. Item (b) does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or any other non-governmental program;
 - c) for the Veteran's Administration, when services are provided to a veteran for a disability which is service-connected;
 - d) for a military hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services; or
 - e) for a group health plan established by a government for its own civilian employees and their dependents.
- 3) **Charge for unnecessary services and supplies** – a charge for services and supplies, including tests or check-up exams that are not needed for medical care of a diagnosed sickness or injury. To be considered "needed," a service or supply must meet all of these tests:
- a) A physician orders it.
 - b) It is commonly and customarily recognized throughout the physician's profession as appropriate in the treatment and diagnosis of the sickness or injury.
 - c) It is neither educational nor experimental in nature. For the purpose of this Plan, investigational procedures are considered experimental.
 - d) It is not furnished mainly for the purpose of medical or other research.

Also in the case of a hospital confinement, the length of the confinement and hospital services and supplies will be considered "needed" only to the extent that they are determined to be:

- a) related to the treatment of the sickness or injury; and
 - b) not allocable to the scholastic education or vocational training of the patient.
- 4) **Charge in excess of reasonable and customary charge** – the portion of any charge for any service or supply in excess of the reasonable and customary charge as determined by the Administrator. The reasonable and customary charge for any service or supply is the usual charge of the provider for the service or supply in the absence of the insurance, but not more than the prevailing charge in the area for a like service or supply. A like service is of the same nature and duration, requires the same skill, and is performed by a provider of similar training and experience. A like supply is one that is identical or substantially equivalent. "Area" means the municipality (or, the case of a large city, the subdivision thereof) in which the service or supply is actually provided or such greater area as is necessary to obtain a representative cross-section of charges for a like service or supply.

- 5) **Dental services charge under the Major Medical Expense Benefit** – a charge for a physician’s services or x-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. This applies even if a condition requiring any of these services involves a part of the body other than the mouth such as the treatment of Temporomandibular Joint Disorders (TMJD) or malocclusion involving joints or muscles by methods including but not limited to, crowning, wiring or repositioning teeth. This exclusion does not apply to charges made for:
- a) Temporomandibular Joint Disorders (TMJD) when the Administrator determines, on the basis of x-rays, study models or other supporting evidence submitted, that internal derangement and degeneration exists, that treatment is appropriate for the existing condition, that a suitable long-term prognosis can be achieved by this treatment and that there is no alternative treatment that is less irreversible and/or less invasive; or
 - b) Treatment or removal of a malignant tumor; or
 - c) Charges for the following dental services received within 12 months after an accident; treatments by a physician, dentist, or dental surgeon of injuries to sound natural teeth (excluding injuries as a result of chewing) including replacement of such teeth, and related x-rays. The charges for these services will be included with the “Expenses Outside the Hospital”; or
 - d) Charges for the removal of unerupted impacted teeth or of a tumor or cyst, or incision and drainage of an abscess or cyst; or
 - e) Hospital charges incurred while hospital confined; or
 - f) Charges for extraction of seven or more teeth at the same time.
- 6) **Foot conditions charges**
- a) Charges for physician services in connection with weak, strained or flat feet, any instability or imbalance of the foot, or any metatarsalgia or bunion; unless the charges are for an open cutting operation and would, except for this part (6), be covered under the coverage.
 - b) Charges for physicians’ services in connection with corns, calluses or toenails; unless the charges are for the following services and would, except for this part (6), be covered under the coverage: the partial or complete removal of nail roots, services reasonably necessary in the treatment of a metabolic or peripheral-vascular disease.
- 7) **Eye care charges under the Major Medical Expense Benefit Plans** – a charge for or in connection with:
- a) Exams to determine the need for (or changes of) eyeglasses or lenses of any type.
 - b) Eyeglasses or lenses of any type except initial replacements for loss of the natural lens.
 - c) Eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- 8) **Blood Charges** – charges for blood or blood plasma that is replaced by or for the patient.
- 9) **Pregnancy Charges** – charges incurred in connection with pregnancy of a dependent child.
- 10) **Impregnation or fertilization charge** – all charges related to or for actual or attempted (a) impregnation or b) fertilization which involves either a covered person or a surrogate as a donor or recipient.

- 11) Sterilization reversal charges** – charges incurred in connection with a surgical procedure to reverse: a) a vasectomy or b) a sterilization tubal ligation.
- 12) Manipulation therapy charges** – charges incurred in connection with treatment of a chronic maintenance condition by manipulation therapy.
- 13) Claims are not covered for sickness or accident charges when a person other than the person for whom the claim is made is considered responsible for the sickness or accident.** Claims considered to be responsibility of someone other than for whom a claim is made will only be paid if payment by or for the responsible person has not been made or the covered individual agrees in writing, on forms supplied by the Administrator, to pay back benefits paid as a result of the sickness or injury with any future payments made by or for the responsible person within 30 days of the responsible person's receipt of payment. Payment will include interest at eight percent compound annually for charges not repaid within 30 days of the date due and for the payment of costs and attorney fees to the Administrator to enforce the agreement. The agreement is applicable whether or not the responsible person admits liability for the payments and/or payments are itemized in any way. Fees and costs incurred to obtain payment from the responsible person will not be deducted from amounts to be repaid to the Administrator unless the Administrator agrees to allow the deduction of reasonable fees and costs in writing. Amounts due to repay benefits, agrees to allow the deduction of reasonable fees and costs in writing. Amounts due to repay benefits, interest, costs and attorney fees may be deducted from other benefits payable by the Administrator after payments are made by or for the responsible person. If benefits are paid by the Administrator, the Administrator has the right to recover them from the person responsible for the sickness or injury. the Administrator may pursue recovery of payments or may permit the covered individual to pursue recovery from the responsible person, at its option. Claims made against a responsible person by a covered individual must include benefit payments made by the Administrator and the covered person must notify the Administrator when the claim is made. No benefits will be paid if a covered person releases or impairs claim or interest against the responsible person in any way without the prior consent of the Administrator or refuses to cooperate or assist the Administrator in obtaining payment from the responsible person.

Coverage Termination

What are the circumstances under which any of my coverages would end?

The coverage for you and your dependents will end if you are no longer an eligible employee.

Definitions For The Purpose Of The Plan

Accident – A non-occupational injury which is:

- 1) Caused by an event which is sudden and unforeseen; and
- 2) Exact as to time and place of occurrence.

Active work requirement – The provision that requires an employee to be actively at work at the business establishment of the participating employer or at any other locations to which the participating employer's business requires the employee to travel.

Admission – Entry into a facility as a registered patient according to the rules and regulations of that facility. An admission ends when the covered person is discharged, or released from the facility and is no longer registered as a patient.

Ambulance – A professionally operated vehicle equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's sickness or injury. Use of the ambulance must be medically necessary and must be the most reasonable method of transportation. This

includes air ambulance service, but only if (a) the person is admitted immediately to the medical facility and (b) the appropriate medical facility is at least 75 or more air miles away. Item (b) does not apply for an emergency life-threatening situation.

Ambulatory surgical center – Any public or private institution that:

- 1) is established, equipped and operated primarily as a facility for performance of surgical procedures and meets the following requirement:
 - a) is operated under the supervision of a staff of physicians, maintains adequate medical records for each patient, and provides for periodic review of the facility and its operation by a utilization and/or tissue committee composed of physicians other than those owning or supervising the facility;
 - b) permits a surgical procedure to be performed only by a physician privileged to perform such procedure in a hospital in its area and requires that a licensed anesthesiologist administer the anesthetics and be present during the surgical procedure, unless only local infiltration anesthetics are used;
 - c) provides no overnight accommodations for patients and at least two operating rooms and one post-anesthesia recovery room and full-time services of registered nurses (R.N.) for patient care in all operating and post-anesthesia recovery rooms;
 - d) is equipped to perform diagnostic x-ray and laboratory examinations required in connection with the surgery to be performed and has the necessary equipment and trained personnel to handle foreseeable emergencies, including, but not limited to, a defibrillator for cardiac arrest, a tracheotomy set for airway obstruction, and a blood bank or other supply for hemorrhaging;
 - e) maintains written agreements with one or more hospitals in its area for immediate acceptance of patients who develop complications or require postoperative confinement; or
- 2) is licensed as an ambulatory surgical center by the state in which the center is located.

Beneficiary – A person or entity named, on a form and in a manner approved by PURMS, to receive benefits for loss of life.

Benefit waiting period – A time of continuous total disability extending for 13 or 26 consecutive weeks (as selected by the participating employer) between the first day of total disability and the day on which benefits begin.

Birthing Center – An institution that meets all of the following requirements;

- 1) The facility is certified or approved by a state department of health or other legally constituted regulatory authority in their state.
- 2) It is equipped and operated primarily for the purpose of providing an alternative method of childbirth. (This would not include an abortion center or clinic.)
- 3) It operates under the direction of a “physician” (meeting the definition of physician in the group policy).
- 4) It permits a surgical procedure to be performed only by a “physician” as in 3 above.
- 5) It requires an examination by an obstetrician at least once prior to delivery (to screen-out high risk pregnancies).
- 6) It offers prenatal and postpartum care.

- 7) It provides at least 2 birthing rooms.
- 8) It has available the necessary equipment and trained personnel to handle foreseeable emergencies. Such equipment shall include a fetal monitor, incubator and resuscitator.
- 9) It provides the services of registered graduate nurses for patient care.
- 10) It does not provide beds or other accommodations for patients to stay more than 24 hours.
- 11) It maintains written agreements with one or more hospitals in the area for immediate acceptance of patients who develop complications or who require post-delivery confinement.
- 12) It provides for periodic review by an outside agency.
- 13) It maintains adequate medical records for each patient.

Calendar Year – The period of time which begins on any January 1st and ends on the following December 31st. When a person first becomes covered under the Group Plan, the first calendar year begins for him or her on the effective date.

Charge in excess of reasonable and customary charge – The portion of any charge for any service or supply in excess of the reasonable and customary charge as determined by the Administrator. The reasonable and customary charge for any service or supply is the usual charge of the provider for the service or supply, but not more than the prevailing charge in the area for a like service or supply. “A like service” is of the same nature and duration, requires the same skill, and is performed by the provider or similar training and experience. “A like supply” is one that is identical or substantially equivalent. “Area” means the municipality (or, in the case of large city, the subdivision) in which the service or supply is actually provided or such greater areas as is necessary to obtain a representative cross-section of charges for a like service or supply.

Child – Your natural born child, legally adopted, or stepchild. The term also includes any child for who you are the legal guardian. The Administrator has the right to request proof of the child’s dependency status. A child other than your natural born child is subject to approval by the Plan administrator.

Copayment – The amount of covered expenses that must be paid by or on behalf of the patient to the provider of services to receive a benefit. This does not include the percentage of expenses payable (coinsurance) or a deductible. (See Deductible and Coinsurance for further information).

Coinsurance – Coinsurance – Coinsurance is the amount of covered expenses you are responsible for paying after you have met any applicable deductibles.

Contributory – The funding of an insurance plan in which the employee pays all or a portion of the cost for his or her coverage.

Convalescent nursing home – A legally operated institution that (a) for a fee, provides room board and 24 hour care by one or more professional nurses and other nursing personnel needed to provide adequate medical care, (b) is under full-time supervision of a doctor or registered nurse (R.N.), (c) keeps adequate medical records, (d) if not operated by a doctor, has the services of one available under an established agreement, (e) is not an institution, or part of one, used mainly as a rest facility or a facility for the aged, and (f) is licensed for skilled nursing care.

Cosmetic – Surgery of other treatment that is for the purpose of improving appearance that is medically unnecessary.

Counseling services – Supportive services provided by members of the hospice team in counseling sessions with the family unit after the death of a terminally ill covered person.

Custodial Care – Care that helps you meet your daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some

examples of custodial care are: assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding and other forms of assistance with normal bodily function; preparation of special diets; and supervision of medication which usually can be self-administered. Custodial care is not covered under this Plan.

Deductible – A certain dollar amount of eligible services that are received (incurred) from a provider and then paid out-of-pocket by the covered person before benefits will be paid by the Administrator. No benefit is payable for any charge used to meet the deductible.

Deductible period for a benefit year – a continuous period composed of the calendar year and the last three months of the previous year (October, November, and December).

Deferment of effective date – If you or any dependent qualified to be covered under this Plan is confined for medical care or treatment either in an institution or at home on the date any coverage, or adjustment thereof, would otherwise become effective for the dependent, such coverage or adjustment will be deferred until his or her final release from all such confinement.

Dependent –

- 1) An employee's legal spouse, or
- 2) An employee's unmarried child (including a stepchild, legally adopted child, or court appointed legal guardianship) from birth and until the date the child attains age 19. Except that, the term "dependent" includes an employee's unmarried child who has attained age 19 while the child is:
 - a) mentally or physically unable to earn his or her own living and proof of incapacity is furnished (and subsequently approved by PURMS) to the Administrator within 31 days of the date his or her coverage would have ended due to age; actually relying on the employee for a majority of his or her support; and covered under this Plan on the date just prior to the day his or her coverage would have ended due to age; or
 - b) in full-time attendance in an accredited school as a full-time student as defined in the rules of the school and is younger than 24 year of age.

To remain insured under "a" or "b" above, proof that the employee's child continues to qualify as a dependent must be furnished (and approved) to the Administrator when requested. The exception is that in the case of "a" above, the Administrator may periodically ask for proof.

- 3) A spouse or child who is covered under the Plan as an employee is not covered as a dependent.

A child cannot be a qualified dependent of more than one employee, when a husband and wife are both employees of the same employer or any employer included under the Group Plan and such coverage is in effect under the Group Plan with respect to their children. One of the employees will be considered a qualified dependent spouse and not an employee for the purpose of such coverage under the Group Plan. The person to be considered a qualified spouse will be determined by the written request of such employees filed with the Administrator.

Determination of need – A determination by SHARE Coordinator, under the terms of the coverage, that approves or disapproves a day or days of inpatient hospital confinement (including hospital services and supplies) as needed for medical care of a diagnosed sickness or injury.

Director – an elected member of the board of directors of a Company.

Director emeritus – A specified former director who functions in an honorary or advisory position, without voting power, to the board of directors of a Company. A director emeritus is eligible only to participate in the director life insurance benefits of the Plan.

Doctor – A physician licensed to practice medicine within the scope of their license.

Durable medical equipment – Equipment recognized as much by Medicare Part B that meets all of the following criteria:

- 1) It can stand repeated in use.
- 2) It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience.
- 3) It is usually not useful to a person in the absence of sickness or injury.
- 4) It is appropriate for home use.
- 5) It is related to the patient's physical disorder.
- 6) It is for temporary use only.
- 7) It is certified, in writing by a physician, as being medically necessary.
- 8) It is the standard, basic model rather than a deluxe, luxury model.
- 9) It is not more costly than alternative services that would be effective for diagnosis and treatment of your condition.
- 10) It enables a patient to make reasonable progress in treatment.

Examples of durable medical equipment include, but are not limited to: wheelchairs, hospital beds, and respirators. Air conditioners, humidifiers, air purifiers, and other similar items are not considered durable medical equipment.

Eligible charges or eligible expenses – Expenses covered under this Plan.

Emergency admission – A hospital admission for an inpatient hospital confinement for a condition which, unless promptly treated on an inpatient basis, would:

- 1) put the patient's life in danger; or
- 2) cause serious damage to a bodily function of the patient.

Employee – A person who is:

- 1) actively working for the employer; and
- 2) receiving earnings.

For the purpose of the Plan, "employee" also means directors and one retained attorney. Not more than three directors emeritus are allowed coverage when an employer provides coverage to such individuals.

Employer – The organization, association, system, entity, etc. from which you receive a salary for performing your job responsibilities and through which you receive the benefits under the Group Plan.

Employment waiting period – The period, if any, of continuous employment required before participation in the Plan is available to an employee.

Evidence of insurability – Satisfactory proof, as determined by PURMS, that a person is acceptable for coverage.

Family unit – An employee and his or her covered dependents.

Home health care agency – Any of the following:

- 1) a hospital which provides a program of home health care, or
- 2) a home health agency as defined for Medicare, or

- 3) an organization which is certified by the patient's physician as an appropriate provider of home health services, is licensed or certified as a home health care agency if the state or local jurisdiction in which it is located requires such licensing or certifications, has a full-time administrator, keeps written records of services provided to the patient, and has a least one registered nurse (R.N.) or one's nursing care available.

Hospice care program – A formal program directed by a doctor to help care for a terminally ill person through either:

- 1) a centrally-administered, medically directed and nurse-coordinated program which:
 - a. provides a coherent system primarily of home care;
 - b. uses a hospice team; and
 - c. is available 24 hours and day, seven days a week; or
- 2) confinement in a hospice.

The program must meet standards set by the National Hospice Organization and approved by the Administrator. If such a program is required by a state to be licensed, certified, or registered, it must also meet the requirement to be considered a hospice care program.

Hospice services – Services and supplies furnished to a terminally ill person by a hospice and/or hospice team.

Hospice team – A team of professionals and volunteer workers who provide care to: (1) reduce or abate pain or other symptoms of mental or physical distress; and (2) meet the special needs arising out of the stresses of the terminal illness, dying and bereavement. The team includes at least: a doctor, a registered nurse; and could include the following: a social worker, a clergyman/counselor, volunteers, a clinical psychologist, Physiotherapist, and occupational therapist.

Hospital – (Only):

- 1) An institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on the accreditation of hospitals, or
- 2) Any other institution that is operated pursuant to law, under the supervision of a staff of physicians and with twenty-four hour a day nursing service, and which is primarily engaged in providing:
 - a) general inpatient medical care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities must be provided on its premises or under its control; or
 - b) specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including x-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital or with a specialized provider of those facilities.
- 4) An institution which does not meet the tests of 1 and 2 above, but which is state licensed and accredited by the Joint Commission for Accreditation of Hospitals as a community mental health center and residential treatment facility for alcoholism and drug abuse or as an ambulatory surgical center.

Except that for care of alcoholism, mental illness and substance abuse, the term "hospital" also means an "alcohol dependency treatment center," "psychiatric day treatment facility," and "drug dependency treatment center" respectively.

Hospital confinement or hospital confined – A covered person is considered confined when he or she is a registered patient in a hospital and a room and board charge is made. A confinement for more than 24 hours is considered an inpatient expense.

Illness –

- 1) a disorder or disease of the body or mind; or
- 2) an accidental injury; or
- 3) pregnancy (only for the purpose of providing benefits under this Plan).

Immunization – An injection with a specific antigen to promote antibody formation to make you immune to a disease or less susceptible to a contagious disease.

Individual – An employee or one of his or her dependents.

Injury – Non-occupational bodily loss or harm.

Intensive care unit – A special unit of a hospital which;

- 1) treats patients with serious sicknesses or injuries;
- 2) can provide special life-saving methods and equipment;
- 3) admits patients without regard to prognosis; and
- 4) provides constant observation of patients by a specifically trained nursing staff.

Manipulation therapy – Treatment, with hands or mechanical means, of those bodily disorders which are disorders of the spine, or disorders involving both the muscles and bones and their connective tissue.

Medicare – A program of medical insurance for the aged and disabled, as established under Title XVIII of the Social Security act of 1965, as amended.

Medical complications of pregnancy – Conditions needing hospital confinement where the diagnosis is different from pregnancy, but the diagnosed condition may be caused or affected by pregnancy.

Medical emergency – A physical condition for which services are required to provide an immediate diagnosis and treatment of a condition which occurs suddenly and unexpectedly and could become a threat to life or limb if medical services were not rendered immediately.

Medically necessary services – Services and supplies ordered by a physician as appropriate in the care and treatment of the patient's diagnosed sickness or injury. In order to be considered medically necessary, the services or supplies must be:

- 1) consistent with the symptom or diagnosis and treatment of the individual's injury or sickness;
- 2) appropriate with regard to standards of good medical practice;
- 3) not solely for the convenience of a doctor, hospital or ambulatory care facility; and
- 4) the most appropriate supply or level which can be safely provided to the individual when applied to the care of an inpatient, it further means that the individual's medical symptoms or conditions require that the services cannot be safely provided to the individual on an outpatient basis.

Further, the services must **not** be educational or experimental in nature, or furnished mainly for the purpose of medical or other research. For the purposes of this Plan, investigational procedures are considered experimental.

Non-contributory – The funding of an insurance plan in which the employee pays no part of the cost of the coverage.

Non-emergency admission – A hospital admission, which is for an inpatient hospital confinement but is not an emergency admission.

Nurse – A registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.).

Oral surgery –The branch of medicine which deals with the diagnosis and surgical treatment of the mouth, jaws and associated structures.

Outpatient – A covered person who is not hospital confined, but is considered a patient because he or she has received treatment in a hospital, treatment facility or office for a medical condition. A confinement for more than 24 hours is considered an inpatient expense.

Outpatient surgery – Surgery that is performed in an approved ambulatory surgical center or the outpatient department of a hospital.

Period of confinement – A single inpatient admission into a hospital. Successive periods of confinement are considered one period unless the second period of confinement is due to injury or sickness related to the condition that caused the first confinement, the confinements will be considered separate if the individual is free of hospital confinement for at least 14 consecutive days.

Periodontics – The branch of dentistry concerned with the study, prevention, and treatment of disease of the tissues and bones supporting the teeth.

Physician – A licensed practitioner of the healing arts acting within the scope of the physician’s practice.

Plan – A noun used generally for the purpose of naming as a whole the benefits, provisions and exclusions as described in this Summary Plan Description.

Preadmission test – Any diagnostic test or study required as part of a hospital’s admission policy or which is necessary for a scheduled surgical procedure, and which is performed within 10 days of an inpatient confinement or outpatient surgery.

Preexisting condition – Under HIPPA, a preexisting condition is a condition for which medical advice, diagnosis, care or treatment was received or recommended within the 6-month period ending on your enrollment date. Pregnancy cannot be treated as a preexisting condition. Preexisting conditions may not be applied to newborns or adopted children covered within 31 days of birth, adoption, or placement for adoption, as long as a child does not incur a break in coverage of 63 days or more.

Pregnancy – Pregnancy, including resulting childbirth, abortion or miscarriage, shall be treated as a sickness for a female employee or spouse.

Primary care doctor – The doctor primarily responsible for a patient’s treatment.

Prosthesis or prosthetic appliance – A device used as an artificial substitute to replace a limb or an eye, used to improve, aid or augment the performance of a natural function. In no event will the term “prostheses” include devices such as eyeglasses, hearing aids, communication devices, orthopedic shoes, arch supports, trusses or examinations for the prescription or fitting thereof.

Reasonable and customary charge – the charge for the covered service or supply usually made by the provider, not to exceed the prevailing charge in the area for a service of the same nature and duration and performed by a person of similar training and experience, or for a substantially equivalent supply.

Relative – (close) – A close relative is considered any of the following:

- 1) Yourself;
- 2) Your Spouse;
- 3) Your child;

- 4) Your brother or sister; or
- 5) Your parent or parent-in-law

Remission – A halt in the progression of a terminal disease; or an actual reduction in the extent to which the disease has already progressed.

Retained attorney – The attorney retained for outside counsel to the Company on an ongoing basis.

Room and board – All services provided by a hospital, including room and meals, nursing services, and all general services and activities needed for the care of registered bed patients.

Routine nursery care – The charges made by a hospital for the use of the nursery. It includes normal services and supplies given to well newborn children following birth. Physician visits are not considered routine nursery care. Treatment of an injury, sickness, birth abnormality, congenital defect following birth and care resulting from prematurity is not considered routine nursery care.

SHARE Coordinator – The person (a registered nurse) who will review the need and/or length of inpatient hospital confinement.

Sickness – Any non-occupational disease or illness. The term also includes: (a) pregnancy (b) any medical complications of pregnancy; (c) a covered newborn's congenital defects or birth abnormalities, including premature birth for which more than routine nursery care is required.

Skilled nursing care – Services that require the expertise of a licensed professional nurse under the direction of a licensed medical physician.

Skilled nursing facility – A facility considered as such under Medicare.

South natural teeth – Teeth that are whole or property restored (and not predisposed to fracture by presence of large restoration) and are without impairment, periodontal or other conditions and are not in need of treatment for reasons other than accidental injury.

Speech therapist – Someone who:

- 1) has a master's degree in speech pathology; and
- 2) has completed an internship; and
- 3) is licensed by the state in which he or she performs his or her services, if that state requires licensing.

Supervising doctor – The doctor directing the hospice care program.

Surgical procedure – Any of the following procedures (excluding oral surgery procedure):

- 1) incision, excision or electro cauterization of any organ or body part;
- 2) reconstruction of any organ or body part of the suture repair of lacerations;
- 3) reduction of a fracture or dislocation by manipulation under general anesthesia;
- 4) use of endoscopes to explore for or to remove

Terminally ill person – A member of the family unit whose life expectancy is six months or less, as certified by the primary attending doctor.

Total disability or totally disabled – Your continuing inability, as a result of injury or sickness, to perform any of the duties of your occupation with your employer. After 24 months, you must be completely unable to work in any job for which you are reasonably fitted by education, training or experience.

Schedule of Benefits

Deductible	\$100 per person \$300 per family
Coinsurance Limit	\$ 5,000 per person \$10,000 per family
Lifetime Maximum	Unlimited
Annual Maximum	\$2,000,000
<u>Physician Benefits</u>	
Office visits	80% of covered services, after deductible
Employee/spouse physical	80% of covered services; one exam per person per year; \$250 maximum allowable charge.
Outpatient Surgery	100% of covered services
Inpatient and office surgery	80% of covered services, after deductible
Hospital visits & services	80% of covered services, after deductible
Second surgical opinion	\$100 % of covered services <u>only</u> if preauthorized by the Administrator; otherwise, 80% of covered services after deductible
Allergy immunizations	80% of covered services, after deductible
HOSPITAL BENEFITS	
Inpatient care (semi-private room & board, anesthesia, miscellaneous services)	100% of the first \$5,000 of covered; then 80% of covered services.
Outpatient surgery – facility free	100% of the first \$5,000 of covered services for surgery at a hospital on an outpatient basis, a freestanding surgical facility, or an approved ambulatory surgical center; otherwise, 80% of covered services.
Emergency room	Accident: 100% of covered expenses, within 72 hours of injury. Illness: 80% of covered services, after deductible.
DIAGNOSTIC LAB & X-RAY BENEFITS	
	80% of covered services, after deductible; 100% of the first \$5,000 of covered services for pre-admission testing within 10 days of inpatient confinement or outpatient hospital surgery.
MENTAL HEALTH/ SUBSTANCE ABUSE BENEFITS	
Inpatient care – hospital services	100% of the first \$5,000 of covered services; then 80% of covered services; maximum lifetime benefit of 120 days of inpatient care.
Outpatient care-physician services	80% of covered services, after deductible; maximum 50 visits per year, \$100 per visit maximum allowable charge.

OTHER MEDICAL BENEFITS

Supplemental accident	100% of covered services within 90 days of an accident, \$300 maximum benefit per accident; then 80% after deductible.
Chiropractic care	80% of covered services, after deductible; visits beyond 30 per year require pre-certification with the Administrator
Physical therapy, speech therapy	80% of covered services, after deductible.
Durable medical equipment	80% of covered services, after deductible.
Ambulance	100% of the first \$5,000 of covered services if due to an accident within 72 hours of injury or resulting in an emergency hospital admission; otherwise, 80% of covered services, after deductible.
Hearing aids	80% of covered services, after deductible; \$750 maximum allowable charge; due to surgery or traumatic injury only.
Private duty nursing	80% of covered services, after deductible; \$10,000 maximum eligible charges per year.
Home Health Care	80% of covered services, after deductible; 4 hours per visit; 60 visits per year; for limited conditions.
Convalescent nursing home care	100% of the first \$5,000 of covered services per confinement, 80% of covered services; maximum daily limit equal to 80% of semi-private room rate of last confinement; maximum 90 days per cause.

HOSPICE CARE

Inpatient hospice	100% of covered services; \$150 limit per day; maximum \$3,000 per period of care.
Outpatient hospice	100% of covered services; maximum \$2,000 per period of care.
Bereavement	\$200 per family unit.
Frames	100% of covered services; maximum 1 set every 24 months; maximum \$60 benefit.

Covered services are subject to reasonable & customary charges.

- 1) Any eligible expenses, which are applied to the deductible in the last three months of the previous calendar year, may be used to satisfy the deductible for the following year.
- 2) The coinsurance limit is the maximum amount of eligible expenses, which have been paid at 80% before the plan reimburses at 100% for the balance of the year.

Employee/spouse physicals, mental health/substance abuse physician services and 50% benefits are not included in this limit.

- 3) This \$5,000 limit includes all expenses incurred during a hospital stay resulting in a room and board charge; i.e., operating room, x-rays, laboratory tests, medicine, anesthetics, ambulance service, and pre-admission x-ray/laboratory tests. Outpatient hospital expenses for emergency care within 72 hours of an accident or surgery are also included in this \$5,000 limit per confinement

NOTE: All hospital admissions require pre certification through SHARE 1-800-52-PURMS.

PRESCRIPTION DRUG BENEFITS	COST TO PATIENT
MAIL SERVICE (Express Scripts)	Up to 90-day supply
Generic drug	\$10 copayment
Brand name drug (required by physician)	\$20 copayment
Brand name drug (by patient choice, when Generic is available)	\$10 copayment, plus difference in and brand name drug
LOCAL PHARMACY NETWORK (Express Scripts)	Up to 30-day supply
Generic drug	\$10 copayment
Brand name drug (required by physician)	\$15 copayment
Brand name drug (by patient choice, when available)	\$10 copayment, plus difference in generic is cost between generic and brand name drug
RETAIL PHARMACY (Pharmacy does not participate in Express Scripts)	Same as Local Express Scripts Pharmacy, but patient must pay difference in cost between Express Scripts cost and retail cost

General “Questions and Answers” About this Benefit

What is the Major Medical Expense Benefit?

The Major Medical Expense Benefit coverage is designed to provide you and your family with benefits for the treatment of injury and sickness. To be eligible for Major Medical Expense Benefits, you must meet certain conditions. The following questions and answers describe these conditions.

What does my expense benefit cover?

Your Major Medical Expense Benefit applies to covered expenses for the treatment of injury and sickness.

What must I do to have the Major Medical expense Benefit coverage without furnishing any medical history or having a pre-existing condition exclusion or benefit restriction?

- You cannot be excluded by employer-assigned class; and
- You must be otherwise eligible; and
- You must complete the PURMS “Enrollment for Participation in Retirement & Insurance Programs” form within 31 days of having satisfied your employer’s eligibility waiting period.

When does coverage end?

The Administrator may amend, modify, change, revise, discontinue or terminate the Plan at any time.

A participant’s and his or her dependent coverage can terminate on the earliest of:

- The day the participant terminates employment,
- The day the participant ceases to be in an eligible class of employees,
- The day the participant fails to make any required contributions to the Plan, or

- The day the participant's employer discontinues the Plan.

If coverage is due to terminate because of the participant's death, coverage for dependents will continue until the earliest of:

- The day required contributions are not made,
- The day the dependent no longer qualifies as a dependent, or
- The day the surviving spouse remarries or dies except as provided by law.

A dependent's coverage can terminate on the day the dependent no longer qualifies as an eligible dependent. A dependent that is physically or mentally incapable of self-support may continue coverage during the period the dependent remains incapacitated and unmarried as long as:

- The dependent continues to be covered by the Plan,
- Proof of incapacity is received within 31 days after coverage would otherwise terminate and at any other time required, and
- The dependent's condition of incapacity is approved by PURMS.

NOTE: Your rights to postretirement benefits are subject to the policies of your employer and can change at any time.

Can medical benefits be continued if a person is enrolled in this coverage and becomes ineligible for it?

Yes. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), all employees and their qualified beneficiaries covered under an employer's health plan have the right to elect to temporarily continue their coverage under the plan if it would end due to certain events, which are known as "qualifying events". Please refer to **COBRA** in the **General Information Section** for more information.

If continued coverage is offered to retirees by your employer, employees terminating employment after age 55 and directors leaving the board at any age are eligible to continue coverage for themselves and their dependents as long as they were covered at the time of the termination of retirement. **NOTE:** Your rights to postretirement benefits are subject to the policies of your employer and can change at any time.

Your benefits Administrator will be able to provide you with information on options available to you and the forms necessary to continue your coverage.

Eligibility

Who is eligible for coverage under the medical plan?

- Eligible employees, unless excluded by job classification, and their eligible dependents
- Retirees and their eligible dependents
- Directors, one retrained attorney and their eligible dependents.

Please refer to Eligibility and Participation in the General Information Section in the front of this Summary Plan Description for more information.

When may I enroll?

When you are hired as an eligible employee, you may enroll yourself, and if applicable, your eligible dependents. After you enroll, you coverage will begin when you complete the eligibility-waiting period.

If you or your dependent is confined for medical care or treatment in any institution or at home on the date coverage would otherwise become effective, the coverage will be delayed until the effective date of the final medical release from the confinement. For example, if your child is confined to a hospital for a

sickness or injury or, if you are not working on the day you would ordinarily become covered, the coverage for you and your dependents will be delayed until you return to work.

Directors and their eligible dependents do not have to satisfy a waiting period. They have 31 days from the date of their election to the board or the date they attend their first board meeting, whichever is later, to sign their application.

What is the eligibility-waiting period?

The eligibility waiting period is the length of time that you must work before you are eligible to be covered by the medical program.

There is no waiting period. When you are hired as an eligible employee, you may enroll and you will be covered on the day you begin work at the Company, or at any location to which your employer's business requires to travel.

What happens if I don't enroll when I first become eligible?

You will be considered a late enrollee and you will be subject to an 18-month preexisting condition exclusion period. You should submit a Certificate of Coverage to prove your prior coverage history in order to decrease the preexisting condition exclusion period by the amount of your creditable coverage.

However, HIPAA established a special enrollment period if you initially declined enrollment for yourself or your dependents (including your spouse) because you were covered by other health insurance and you stated in writing that this was the reason coverage was declined. You will be able to enroll yourself or your dependents in this plan, provided that your request enrollment within 31 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Please refer to HIPAA in the **General Information Section** in the front of this Summary Plan Description for more information.

Benefit Cost

Who pays the cost of the benefit?

The cost of the benefit is being paid by your employer without any cost to you.

Deductible

Is there a deductible that must be satisfied?

Yes. A deductible is the first \$100 of medical expenses incurred by you and each of your dependents each calendar year. Each covered individual must satisfy the deductible once each calendar year. But, when covered members of a family unit (you and your dependents) collectively incur a total of \$300 of eligible charges, all individual deductible amounts will thereafter be considered as met for all covered members of the family unit for the remainder of that calendar year.

How are the deductible handled if two or more family members are injured in the same accident?

If two or more covered family members are injured in the same accident, only one yearly deductible will be charged to their combined eligible expenses due to an accident.

What is the Deductible Carry-over Provision?

Although a new deductible will apply each calendar year, expenses incurred during the last three months of a year (October, November and December) which are applied against that year's deductible will also

be applied toward the deductible for the following year. This may reduce or eliminate that next year's deductible.

What expenses are covered after the deductible is satisfied?

After you or a covered dependent has satisfied the deductible within a calendar year, your Major Medical coverage will pay the benefits listed on later pages for all additional eligible expenses incurred by that person during the rest of the year.

Coinsurance Limit

What is the coinsurance limit?

When \$5,000 in eligible expenses for an individual (\$10,000 per family) has been paid at 80% in a calendar year, the Plan will reimburse at 100% for the balance of the year. Employee/spouse physicals, mental health/substance abuse physician services and 50% benefits are not included in this limit.

In-patient Hospital

NOTE: Eligible expenses for hospital confinements and convalescent nursing home care following certain hospitalization may be limited; see Simplified Hospital Admissions Review (SHARE) on a later page.

What are the eligible in-patient hospital expenses?

The eligible expenses are the charges incurred for the following services and supplies for the treatment of injuries and sickness:

- 1) **Room and board** – charges for room and board. Any charges above the semi-private room rate will be considered ineligible by the Plan. If a hospital does not have semi-private rooms, the limit is 90% of the daily charge for its lowest rate private room.
- 2) **Other hospital services** – expenses incurred during a hospital stay resulting in a room and board charge for:
 - a) services and supplies furnished by the hospital for medical care such as operating room, x-rays, laboratory tests, medicines, etc., but not professional services,
 - b) administration of anesthetics by a doctor, and
 - c) ambulance service to the nearest appropriate medical facility. Pre-admission x-ray and laboratory tests in the hospital are also included provided the resulting confinement starts within 10 days.

Even if there is no room and board charge, the expenses for the services and supplies in item 2 above will be paid under this part of the Plan if the visit is for emergency care within 72 hours after an accident, or if it is for a surgical procedure or pre-surgery x-ray and lab exams made within 10 days of the surgical procedure. Otherwise these expenses will be combined with the **Other Medical Expenses** as listed on a later page.

Separate hospital confinements due to the same cause will be considered one confinement unless separated by 14 or more days, or (in the case of an employee) separated by return to work.

What is the benefit for eligible in-patient hospital expenses?

Your major medical coverage pays 100% of the first \$5,000 eligible expenses for each confinement (up to the hospital's standard most common semi-private room rate). Eligible amounts over \$5,000 will be paid at 80%

What is covered in the case of mental/nervous or substance abuse?

In the case of mental/nervous or substance abuse, in-patient hospital expenses will be paid only for 120 inpatient days in a lifetime, provided that such expenses are part of an approved treatment plan.

Convalescent Nursing Home Care

NOTE: Eligible expense for hospital confinements and convalescent nursing home care following certain hospitalization may be limited; see Simplified Hospital Admissions Review (SHARE) on a later page.

Is there some provision for convalescent nursing home care?

Provision is made for covered expenses for convalescent nursing home care following certain hospitalizations.

What is the convalescent nursing home care expense benefit?

This part of your Plan provides benefits for eligible expenses incurred during a covered convalescent nursing home care confinement after a hospital stay of at least 3 consecutive days that was covered by the Plan. The confinement must start within 15 days after release from the hospital and must be recommended by the doctor attending the condition causing the hospitalization.

What are the eligible convalescent nursing home care expenses?

The eligible expenses are the nursing home charges – up to a daily limit equal to 80% of the standard (most common) semi-private room rate in the hospital from which the patient was transferred – for the following services and supplies furnished while the patient is under continuous care of his doctor and requires 24-hour skilled nursing care:

Room, board and other services and supplies furnished by the home for necessary care (other than personal items and professional services).

The above expenses will be considered additional hospital bills and combined with the bills for the prior hospital confinement in determining the amount to be paid under the Major Medical Expense Benefit.

What does the convalescent nursing home care benefit not cover?

Custodial care services or supplies provided to assist a person in daily living (e.g., meals and personal grooming) are not covered.

Is there a time limit applied to convalescent nursing home care?

A 90-day limit applies to all nursing home care due to the same or related causes.

Eligible Surgical Expenses

Does it matter if I pre-authorize a consultation for a second surgical opinion before surgery?

Yes. The benefit for a second surgical opinion is payable at 10% if the consultation is pre-authorized by the Administrator. The benefit is considered and payable as a physician service if the consultation is not pre-authorized by the Administrator. the Administrator's telephone number is 402-483-9200.

What are eligible surgical expenses?

The Plan will pay 80% of the reasonable and customary fees, after deductible for the following eligible doctor's services:

- 1) Performance of a surgical procedure as defined in **Definitions for the Purpose of the Plan.**
- 2) Assistance with the surgical procedure where required by the nature of the procedure or by the patient's condition, not performed in a hospital having available staff physicians qualified

to provide such assistance. These eligible surgical expenses will be limited to 20% of the reasonable and customary amount of the surgeon's fee.

Surgeries that are investigational or experimental in nature are not eligible.

What does “surgical procedure” mean?

A “surgical procedure” means cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, elect cauterizing, tapping (paracentesis), applying plaster casts, administering pneumothorix, endoscopy or injecting sclerosing solution. Also, reference “surgical procedure” in **Definitions for the Purpose of the Plan.**

Are the charges for organ transplants eligible expenses?

Charges for certain organ transplants are considered as eligible expenses provided these charges are deemed medically necessary by the Administrator.

What does the surgical expense benefit not cover?

The surgical expense benefit **does not** cover:

- 1) cosmetic surgery, unless due to a congenital defect which impairs the function of a body organ, or an accident occurring while covered.
- 2) surgeries that are investigational or experimental in nature.

What benefits are included in The Women’s Health and Cancer Rights Act of 1998?

Beginning January 1, 1999, Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy and who elects breast reconstruction:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes.)

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Also see **Generally Excluded Charges, Definitions for the Purpose of the Plan and Coordination with Other Medical Plans** in the **General Information Section** in the front of this Summary Plan Description.

Outpatient Surgical Expenses (Excludes office setting)

This part of the Plan will be paid when a doctor performs a covered outpatient surgical procedure.

The Plan pays 100% of the reasonable and customary charges for an outpatient surgical procedure when performed in a hospital on an outpatient basis, a free standing surgical facility or an ambulatory surgical center

Expenses to the extent they are payable under other parts of the Plan are not eligible under this benefit.

Does it matter if I pre-authorize a consultation for a second surgical opinion before surgery?

Yes. The benefit for a second surgical opinion is payable at 100% if the consultation is pre-authorized by the Administrator. The benefit is considered and payable as a physician service if the consultation is not pre-authorized by the Administrator. The Administrator's telephone number is 1-800-562-5226.

What does “surgical procedure” mean?

A “surgical procedure” means cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, elect cauterizing, tapping (paracentesis), applying plaster casts, administering pneumothorix, endoscopy or injecting sclerosing solution. Also, reference “surgical procedure” in **Definitions for the Purpose of the Plan**.

The surgical suite or facility must be accredited by either the Accreditation for Ambulatory Health Care (AAHC) or the American Association of Accreditation Plastic Surgery Facilities (AAPSE).

What is the benefit for eligible outpatient surgical hospital expenses?

Your major medical coverage pays 100% of the first \$5,000 of eligible expenses:

- 1) services and supplies furnished by the hospital for medical care such as operating room, x-rays, laboratory tests, medicines, etc., but not professional services;
- 2) administration of anesthetics by a doctor;
- 3) ambulance service and pre-surgery x-ray and laboratory exams made within 10 days of the surgical procedure.

What does the outpatient surgical expense benefit not cover?

The outpatient surgical expense benefit does not cover cosmetic surgery, unless due to a congenital defect that impairs the function of a body organ, or an accident occurring while covered.

Surgeries that are investigational or experimental in nature are not eligible.

Also see **Generally Excluded Charges, Definitions for the Purpose of the Plan and Coordination with Other Medical Plans** in the **General Information Section** in the front of this Summary Plan Description.

Mental Health and Substance Abuse Benefits

What are the combined mental health and substance abuse benefits of this Plan?

The Plan covers charges incurred for the treatment of mental, psychoneurotic, personality disorder, and substance abuse as indicated in the Schedule of Benefits, up to the following limits:

- 1) Hospital inpatient confinement – maximum lifetime benefit of 120 days of inpatient care.
- 2) Outpatient visits – maximum 50 visits per year, \$100 per visit maximum allowable charge.
- 3) To comply with the Mental Health Parity act of 1996, there will be no lifetime maximum benefit payment for mental and nervous claims.

Also see **Generally Excluded Charges, Definitions for the Purpose of the Plan and Coordination with Other Medical Plans** in the **General Information Section** in the front of this Summary Plan Description.

Diagnostic X-ray and Laboratory Expenses

What is diagnostic x-ray and laboratory expense coverage?

This coverage is for eligible diagnostic x-ray and laboratory expenses made necessary by an injury or sickness. Eligible expenses are covered at 80%, after deductible. For pre-admission testing within 10

days of inpatient confinement or outpatient hospital surgery, eligible expenses are paid at 100% of the first \$5,000.

What is the intent of this coverage?

The benefits are intended for x-ray and laboratory examinations made outside the hospital. However, they also apply to examinations in a hospital; when the hospital visit is on an outpatient basis for a reason other than emergency care following an accident or performance of surgery and occurs at least 10 days before confinement as an inpatient.

What is not covered?

The benefit does not cover the portion of a charge paid under another part of the Plan.

Also see **Generally Excluded Charges, Definitions for the Purpose of the Plan and Coordination with Other Medical Plans** in the **General Information Section** in the front of this Summary Plan Description.

Supplemental Accident Expenses

This part of the Plan provides benefits for certain expenses due to an accident occurring while covered.

The benefit pays 100% of covered expenses, up to \$300 per accident.

The Plan will pay toward the expenses incurred within 90 days after the accident for the following services and supplies, but only to the extent the expenses are not paid under other parts of the Plan:

- 1) Hospital services and supplies for medical care.
- 2) Doctors' services for surgery and other medical care.
- 3) Dental treatment: treatment by a dentist, physician or dental surgeon of a fractured jaw or injuries to sound natural teeth, including their replacement.
- 4) X-ray and laboratory examinations for medical care.
- 5) Services of a registered graduate nurse other than a close relative. "close relative" refers to you or your spouse, or to a child, brother, sister or parent of you or your spouse.
- 6) Drugs and medicines dispensed by a licensed pharmacist.
- 7) Surgical dressings, casts, splints, trusses, braces and crutches.

What does the Supplemental Accident Expense benefit not cover?

The supplemental accident expense benefit does not cover:

- 1) An accident occurring before an individual is covered.
- 2) The portion of an expense paid under another part of the Plan.

Also see **Generally Excluded Charges, Definitions for the Purpose of the Plan and Coordination with Other Medical Plans** in the **General Information Section** in the front of this Summary Plan Description.

Pregnancy Benefits

What are the pregnancy benefits?

The benefits for expenses due to pregnancy of a female employee or employee's wife are paid the same as any non-maternity illness.

What are the newborn baby care benefits?

Charges for the following services and supplies incurred during the 31 days immediately following the birth of a newborn child of a covered individual will be considered as reasonably necessary charges for the child's care.

- 1) Hospital room and board,
- 2) Other services and supplies provided by the hospital for care, but not professional services; and
- 3) Hospital visits made by a doctor.

If the baby's mother is a dependent spouse and not covered, any charges incurred by the baby related to birth, illness or accident will be covered up to 31 days.

Is there any special assistance for enrolling a child at birth?

If the request to cover a newborn, whether your natural child or one for whom adoption is being processed, is made within 31 days of the birth of the child, the coverage will automatically be effective on the birth date.

What is the minimum length of hospital stay in connection with childbirth?

The Newborns' and Mothers' Health Protection Act of 1996 requires both individual and group health plans that cover childbirth to provide at least 48 hours of hospital stay for the mother and newborn following a normal vaginal delivery, or at least 96 hours following a cesarean section. Earlier discharge is permitted if agreed to by both the attending provider and the mother, however, insurers or plans may not provide incentives for earlier discharges.

Plans may not, under Federal law, require the attending provider to obtain prior authorization from the plan to prescribe a hospital length of stay up to 48 hours (96 hours for cesarean section) for childbirth. However, a plan may require pre-certification for any part of a stay after 48 or 96 hours, or for the entire day.

Also see **Generally Excluded Charges, Definitions for the Purpose of the Plan and Coordination with Other Medical Plans** in the **General Information Section** in the front of this Summary Plan Description.

Annual Physical Examination Expenses

Adult / Child benefit limited to \$500 per calendar year.

Annual Physical Examination

Covered Benefits: Services covered by the Plan under this benefit include well-baby / child care and routine physical examinations, including charges for routine laboratory and x-ray associated with such examinations. Preventive care includes outpatient services specifically provided to monitor and maintain the patient's health and/or to prevent illness.

Well-Baby and Well-Child Care:

The Plan will cover routine well care under the following guidelines of the United States Department of Health:

- Immunizations will be considered eligible expenses and 80% of cost will be paid by the Plan if approved and paid for by the State of Washington Health Vaccines Program.

Routine Physical Exams for Adults:

Mammograms are covered in accordance with the following schedule (unless medically necessary) and are excluded from the \$500 routine care benefit maximum amount:

- one baseline mammogram for women age 35 through 39;
- one mammogram annually for women age 40 and over.

Colonoscopy procedures (colonoscopy, flexible sigmoidoscopy, virtual colonoscopy) are covered in accordance with the following schedule (unless medically necessary and/or requested by the physician):

- Beginning at age 50 and thereafter as requested and/or recommended by the physician;
- Prior to age 50 if there is a family history of colon polyps or colon cancer.

The Plan will cover routine physical examinations for adults (age 19 and over), as well as to monitor and maintain health and/or to prevent illness.

Immunizations will be covered under this benefit when deemed necessary to maintain health and/or prevent illness. Benefits are limited to a maximum of \$500 (excluding mammograms and colonoscopy procedures) paid by the Plan each calendar year.

Charges for preventive care services provided under the terms of this benefit are provided and are not subject to the deductible.

Alternative Medicine

What are the annual Alternative Medicine benefits?

Services provided and billed by a licensed Naturopath, Acupuncturist, Massage therapist, Registered Dietitian services and Certified Nutritionist.

How much will the Plan pay for Alternative Medicine?

After applicable co-payments are paid, the Plan will pay 80% of allowed charges after the deductible is met, up to the following annual maximums:

Benefits are limited to a combined annual maximum of \$1,000 in paid claims.

All of these alternative medicine services may be self-referred.

What does this benefit not cover?

This benefit does not cover:

- 1) Services of a Homeopath.

Other Medical Expenses

What other expenses may be covered that have not been discussed in previous questions?

Other medical expenses include a wide range of services and supplies, as listed below. Of course, any portion of these expenses paid under the benefits already described will not be eligible under this part.

Doctor's services – home, office and hospital visits, and other medical care and treatment.

Nursing care – out of hospital private duty nursing services for a registered graduate nurse who is not a close relative. In-hospital private duty nursing is not covered.

Speech therapy – by a qualified speech therapist other than a close relative to restore speech loss, or correct an impairment, due to (a) a congenital defect for which surgery has been performed, or (b) an injury or sickness but not a mental, psychoneurotic or personality disorder.

Phsiotherapy – treatment by a physiotherapist.

Second surgical opinion – the benefit for a second surgical opinion is payable at 100% if the consultation is pre-authorized by the Administrator. The benefit is considered and payable as physician service if the consultation is not pre-authorized by the Administrator. the Administrator’s telephone number is 402-483-9200.

Chiropractic – more than 30 chiropractic visits within a calendar year require pre-certification of appropriate medical care. Please call Company Benefit Administration at 402-483-9200 to pre-certify coverage before expenses are incurred for more than 30 chiropractic visits within a calendar year.

Ambulance service to the nearest appropriate medical facility. This includes air ambulance service in the event of a life threatening condition as determined by the Administrator.

X-ray and radium treatments and treatments with other radioactive substances.

Medical supplies – blood and blood plasma not replaced by or for the patient; artificial limbs, eyes and larynx; electronic heart pacemaker; surgical dressings, casts, splints; trusses; braces; crutches; rental of wheel chair, hospital bed, or iron lung; oxygen and rental of equipment for its administration.

Contact lenses and eyeglasses – necessitated by and obtained immediately following a cataract operations, but not to exceed the reasonable and customary charge; provided that no benefit will be payable unless medically necessary and provided that no benefits be payable for replacement of contact lenses or eyeglasses due to loss, breakage or prescription change.

Hearing aids – necessitated by impairment of hearing following car surgery or due to traumatic injury but not to exceed a maximum allowable charge of \$750 (maximum benefit of \$600) per ear. No benefit will be payable for replacement of a hearing aid for any reason.

What are the eligible expenses for private duty nursing?

For any one covered individual, not more than \$10,000 in a calendar year will be counted as eligible expenses for private duty nursing services by a registered graduate nurse. The following conditions must also be met.

- 1) The patient is not in a hospital or other institution that provides nursing services, and
- 2) The services are required to treat an acute illness.

This benefit is designed to provided professional nursing care to individuals whose health and welfare would be endangered without the skill and training of a registered nurse. Benefits will not be paid for services that:

- 1) are mainly custodial, or
- 2) are mainly to assist the patient with the functions of daily living or to dispense or medication, or
- 3) could be properly furnished by someone who does not have the professional qualification of a registered graduate nurse.

Home Health Care Expense Benefit

What does the home health care expense benefit provide?

This part of the Plan provides benefits for the services and supplies furnished by a home health care agency to you or covered dependent.

The benefits are subject to the following conditions:

- 1) The patient is under the care of a doctor who submits a “home health care plan” (a written program for care and treatment of a sickness or injury in the patient’s home, and certification

that inpatient confinement in a hospital, convalescent nursing home or skilled nursing facility would be required if the home care weren't provided).

- 2) The services and supplies are ordered by a doctor as a part of the "home health care plan" and are furnished during the period inpatient confinement in a hospital, convalescent nursing home or skilled nursing facility would be required were it not for the home health care.

The Plan will pay the eligible charges made to you by the home health care agency, but not to exceed these limits:

- 1) For services furnished directly to a person during home health care visits, benefits will be payable for not more than 60 visits in a calendar year. A visit of four hours or less is counted as one visit. If a visit exceeds four hours, each four hours or fraction is counted as a separate visit.
- 2) For other services and supplies, the benefit will not exceed the amount that would have been payable under the Major Medical Expense Benefit had they been furnished by a hospital during an inpatient confinement. For this purpose, a continuous period during which inpatient care in a hospital, convalescent nursing home or skilled nursing facility would be required were it not for the home care, will be considered a hospital confinement.

To the extent benefits are payable for charges under the home health care expense benefit, the charges will be excluded under the Major Medical Expense Benefit.

What does the home health care expense benefit not cover?

The home health care expense benefit does not cover services rendered by you, spouse, or a child, brother, sister or parent of you or spouse. Services provided by home health aides are not covered. Custodial care services or supplies provided to assist a person in daily living (e.g., meals and personal grooming) are not covered.

The exclusions that apply to the Major Medical Expense Benefit also apply to the home health care expense benefit.

Also see **Generally Excluded Charges, Definitions for the Purpose of the Plan and coordination with Other Medical Plan** in the **General Information Section** in the front of the Summary Plan Description.

Hospice Care Expense Benefit

What does the hospice care expense benefit provide?

This coverage supplement pays benefits for charges incurred for a terminally ill covered person while in a Hospice Care Program. The primary care doctor must give certification of the terminal illness to the Administrator.

What conditions must be met for hospice care benefits to be paid?

Benefits will be paid if the hospice stay or the hospice services are:

- 1) Provided while the terminally ill person is a covered individual;
- 2) Ordered by the supervising doctor as part of the Hospice Care Program;
- 3) Charged for by the Hospice Care Program; and
- 4) Provided within 6 months of the terminally ill person's entry or re-entry (after a remission period) in the Hospice Care Program.

What charges will be paid while not an inpatient in a hospice?

The coverage supplement will pay the charges incurred for all hospice services for one period of care in the Hospice Care Program up to a maximum outpatient benefit of \$2,000.

What are the maximum charges that will be paid while an inpatient in a hospice?

The coverage supplement will pay the charges incurred for one period of care in the Hospice Care Program up to the maximum daily hospice inpatient benefit of \$150, and the total maximum hospice inpatient benefit of \$3,000.

All periods of care in the Hospice Care Program will be considered related and to have occurred in the one period of care unless separated by at least 3 consecutive months.

Are there bereavement benefits under the Hospice Care Program?

This coverage supplement provides benefits for charges incurred for counseling services for the family unit, if ordered and received under the Hospice Care Program.

What are the conditions for receiving bereavement?

The benefits will be paid if (1) on the day prior to death the terminally ill person was in the Hospice Care Program, a member of the family unit, and a covered individual; and (2) the charges are incurred by the family unit within three months following the date the terminally ill person dies.

The coverage supplement will pay the charges up to a maximum bereavement benefit per family unit of \$200.

Which charges are not covered?

The following charges are not covered:

- 1) Charges for the treatment of a diagnosed sickness or injury of a family unit member to the extent that benefits are payable under another coverage of the Plan. If benefits of such coverage are expressed as a percent of charges, this exclusion will apply as if the percent were 100%
- 2) Charges for services provided by yourself, spouse, or a child, brother, sister or parent of yourself or spouse.
- 3) Charges incurred during a remission period. This applies if, during remission, the terminally ill person is discharged from the Hospice Care Program.

Also **Generally Excluded Charges, Definitions for the Purpose of the Plan and Coordination with Other Medical Plan** in the **General Information Section** in the front of the Summary Plan Description.

Major Medical Expense Benefit Exclusions

What does the Major Medical Expense Benefit not cover?

In addition to the Plan's general exclusions, the Major Medical Expense Benefit does not cover:

- 1) Nursing, speech therapy, physician's services, or physiotherapy rendered by yourself, spouse, or a child, brother, sister, or parent of yourself or spouse
- 2) Services or supplies received as a result of an act of war occurring while covered.
- 3) Expenses in connection with cosmetic surgery unless due to an accident occurring while covered.
- 4) Charges for exams to determine the need for hearing aids or the need to adjust them.
- 5) Expenses incurred for treatment of injuries from the commission of a felony.

- 6) Expenses in connection with an injury to the extent payment is the responsibility of a third party. The Plan will pay benefits if the employee agrees, in writing, to repay such benefits to the extent payment is made to him by the person responsible for the injury (as a settlement, judgment or in any other way).
- 7) Expenses applied toward satisfaction of the deductible previously described.
- 8) Expenses incurred by a dependent child for pregnancy.

Also see **Generally Excluded Charges, Definitions for the Purpose of the Plan and Coordination with Other Medical Plans in the General Information Section** in the front of this Summary Plan Description.

VISION CARE EXPENSE BENEFIT

What is the vision care expense benefit?

The coverage will pay the charges for eye examinations made by a doctor, for eyeglass lenses or contact lenses prescribed by a doctor, and for eyeglass frames, up to the applicable limits shown in the Schedule of Benefits. A doctor or an optician must furnish lenses and frames.

What does “optician” mean?

“Optician” means a person whose services included the preparation or ordering of ophthalmic lenses based on prescription, and the furnishing of eyeglass frames. An optician is legally qualified to perform these services in the jurisdiction in which the services are rendered.

What must I do to have the Vision Care Expense Benefit coverage having a benefit restriction?

- You cannot be excluded by employer-assigned class; and
- You must be otherwise eligible; and
- You must complete the PURMS “Enrollment for Participation in Retirement & Insurance Programs” form within 31 days of having satisfied the employer’s eligibility waiting period.

When does coverage end?

The Administrator may amend, modify, change, revise, discontinue or terminate the Plan at any time.

A participant’s and his or her dependent coverage can terminate on the earliest of:

- The day the participant terminates employment,
- The day the participant ceases to be in an eligible class of employees,
- The day the participant fails to make any required contributions to the Plan, or
- The day the participant’s employer discontinues the Plan.

If coverage is due to terminate because of the participant’s death, coverage for dependents will continue until the earliest of:

- The day required contributions are not made,
- The day the dependent no longer qualifies as a dependent, or
- The day the surviving spouse remarries or dies except as provided by law.

A dependent’s coverage can terminate on the day the dependent no longer qualifies as an eligible dependent. A dependent that is physically or mentally incapable of self-support may continue coverage during the period the dependent remains incapacitated and unmarried as long as:

- The dependent continues to be covered by the Plan,
- Proof of incapacity is received within 31 days after coverage would otherwise terminate and at any other time required, and
- The dependent’s condition of incapacity is approved by PURMS.

NOTE: Your rights to postretirement benefits are subject to the policies of your employer and can change at any time.

Can vision benefits be continued if a person is enrolled in this coverage and becomes ineligible for it?

Yes. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), all employees and their qualified beneficiaries covered under an employer’s health plan have the right to elect to temporarily continue their coverage under the plan if it would end due to certain events, which are known as “qualifying events”. Please refer to **COBRA** in the **General Information Section** for more information.

If continued coverage is offered to retirees by your employer, employees terminating employment after age 55 and directors leaving the board at any age are eligible to continue coverage for themselves and their dependents as long as they were covered at the time of the termination or retirement. **NOTE:** Your rights to postretirement benefits are subject to the policies of your employer and can change at any time.

The Administrator will be able to provide you with information on options available to you and the forms necessary to continue your coverage.

What are the limitations on the vision care benefit under this Plan?

If you and/or your dependent do not enroll into the Vision Expense Benefit Plan within 31 days after first becoming eligible coverage will be limited and will not include lenses and frames during the first year of participation in the Plan.

The vision care benefit is limited to:

- 1) Not more than one eye examination per person during any twelve consecutive months.
- 2) Not more than two lenses or two contact lenses or disposable contact lenses per person during any twelve consecutive months. (In the case of disposable contact lenses, not more than a twelve-month supply of disposable contact lenses during any twelve consecutive months. A twelve-month supply is defined by the specific manufacturer’s recommended usage guidelines.)
- 3) Not more than one set of frames per person during any twenty-four consecutive months to a maximum \$60 benefit.

Schedule of Benefits

Vision Care Expense Benefit	Amounts
Eye Examinations	100% of eligible charges, maximum one exam every 12 months.
Lenses or Contacts (1)	100% of eligible charges, maximum Two lenses every 12 months.
Disposable Contact Lenses (1)	100% of eligible charges, up to a 12-month supply every 12 months.
Frames	100% of eligible charges, maximum one set every 24 months; maximum \$60 benefit.

Benefit is limited to either 2 lenses or 2 contact lenses or a 12-month supply of disposable contact lenses every 12 months. A twelve-month supply is defined by the specific manufacturer's recommended usage guidelines.

Eligibility

Who is eligible for coverage under the Vision Care Expense Benefit Plan?

- Eligible employees, unless excluded by job classification, and their eligible dependents
- Retirees and their eligible dependents
- Directors, one retained attorney and their eligible dependents

Please refer to **Eligibility and Participation** in the **General Information Section** in the front of this Summary Plan Description for more information.

When may I enroll?

When you are hired as an eligible employee, you may enroll yourself, and if applicable, your eligible dependents. After you enroll, your coverage will begin when you complete the eligibility-waiting period.

If you or your dependent is confined for medical care or treatment in any institution or at home on the date coverage would otherwise become effective, the coverage will be delayed until the effective date of the final medical release from the confinement. If you are not working on the day you would ordinarily become covered, the coverage for you and your dependents will be delayed until you return to work. This is the active Work Requirement provision.

Directors and their eligible dependents do not have to satisfy a waiting period. They have 31 days from the date of their election to the board or the date they attend their first board meeting, whichever is later, to sign their application.

What is the eligibility-waiting period?

The eligibility waiting period is the length of time that you must work before you are eligible to be covered by the Vision Care Expense Benefit Plan.

There is no waiting period. When you are hired as an eligible employee, you may enroll and you will become covered on the day you begin work at the Company or at any location to which your employer's business requires you to travel.

Exclusions

What is not covered by this vision care benefit?

This benefit does not cover:

- 1) Services and supplies:
 - a) in connection with special procedures such as orthoptics, vision training, subnormal vision aids and tonography, or
 - b) in connection with medical or surgical treatment of the eye.
- 2) Photosensitive, antireflective, or aniseikonic lenses to the extent charges exceed the charge for clear, white lenses.
- 3) Sunglasses or other tinted glasses of any kind to the extent charges exceed the charge for clear, white lenses.
- 4) A service or supply to the extent covered under any other coverage or plans, insured or uninsured, for which the employer pays, directly or indirectly, all or part of the cost.

- 5) A service or supply, which the employer is required by law to furnish in whole or in part.
- 6) A service or supply, which is not needed for vision care of a covered individual.

Also see **Generally Excluded Charges, Definitions for the Purpose of the Plan and Coordination with Other Medical Plans** in the **General Information Section** in the front of this Summary Plan Description.

WEEKLY SHORT TERM DISABILITY BENEFIT PLAN

What is the Weekly Short Term Disability Benefit Plan?

You will receive weekly short-term disability (STD) benefit payments if you are unable to work because of a covered non-occupational accident or sickness and are under the regular care of a physician. The amount of the payment and the day it begins are shown in the Schedule of Benefits.

What must id do to have the weekly short-term disability coverage without furnishing any evidence of insurability?

- You cannot be excluded by employer-assigned class; and
- You must be otherwise eligible; and
- You must complete the PURMS “Enrollment of Participation in Retirement & Insurance Programs” form within 31 days of having satisfied your employer’s eligibility waiting period.

Schedule of Benefits

ElectREwage Weekly Short Term Disability Benefit Plan

Benefits	Amounts
Weekly Payment	66 2/3 % of employee’s weekly earnings* up to a maximum weekly payment of \$500.
Benefit Period Begins	On the eighth consecutive day of disability.
Maximum Benefit Period	26 weeks

*Based on the employee’s earnings for a normal work week, not exceeding 40 hours, exclusive of bonus, deferred compensation and overtime pay.

Eligibility

Who is eligible?

- Eligible employees, unless excluded by job classification.

Please refer to **Eligibility and Participation** in the **General Information Section** in the front of this Summary Plan Description for more information.

When may I enroll?

When you are hired as an eligible employee, you may enroll. After you enroll, your coverage will begin when you complete the eligibility-waiting period.

If you are not working on the day you would ordinarily become covered, your coverage will be delayed until you return to work. This is the Active Work Requirement provision.

What is the eligibility-waiting period?

The eligibility waiting period is the length of time that you must work before you are eligible to be covered by the disability program.

There is no waiting period. When you are hired as an eligible employee, you may enroll, and you will become covered on the day you begin work at the employer, or at any location to which your employer's business requires you to travel.

Weekly Short Term Disability Benefit Value

What is the amount of my weekly short-term disability (STD) benefit?

Your weekly benefit is 66 2/3% of your basic weekly earnings*, with a maximum weekly benefit of \$500.

*Based on earnings for a normal workweek, exclusive of bonus, deferred compensation and overtime pay in effect at the time of disability.

Length of Weekly Short Term Disability Benefits

When does my disability benefit period begin?

Your weekly short-term disability (STD) benefits begin on the eighth consecutive day on which you are unable to work due to a covered accident or sickness.

How long are benefits paid?

Your maximum benefit period is 26 weeks.

Successive disabilities separated by less than two weeks of work will be considered one disability, unless the subsequent disability is due to a different cause and does not begin before you return to work.

When does my coverage end?

In this situation

Your employment terminates or you transfer to an employee group the Plan does not cover.

You retire from the company

You are on leave of absence for reasons other than Disability.

The Plan is terminated, changed or no longer covers Your employee group.

If your group STD coverage under this Plan terminates, it may not be converted to an individual policy.

This happens to your

eligibility for coverage

Coverage ends immediately.

Coverage ends immediately.

Coverage continues through last day worked.

Coverage ends immediately.

Weekly Short Term Disability Benefit Plan Exclusions

What is not covered by the Weekly Short Term Disability Benefit Plan?

Benefits will not begin until the eighth consecutive day of disability.

The benefit does not cover disability due to an accident related to any employment, or sickness covered under Workers' Compensation or similar law, except when furnished to an individual proprietor or partner who is covered as an employee and who cannot be covered Workers' Compensation.

DENTAL EXPENSE BENEFIT

What is the Dental Expense Benefit?

The Dental Expense benefit is designed to provide you and your family with reimbursement for certain dental expenses you incur. To be eligible for Dental expense Benefits, you must meet certain conditions. The following questions and answers describe these conditions.

What does my dental expense benefit cover?

Dental expense benefits cover work included in a broad list of dental services, divided into “preventive services” “diagnostic services,” “basic services,” and “major services.” A list of dental services is included in **List of Dental Services** on a later page.

What must I do to have the dental expense benefit coverage without having benefit restrictions?

- You cannot be excluded by employer-assigned class; and
- You must be otherwise eligible; and
- You must complete the PURMS “Enrollment for Participation in Retirement & Insurance Programs” form within 31 days of having satisfied your employer’s eligibility waiting period.

When does coverage end?

The Administrator may amend, modify, change, revise, discontinue or terminate the Plan at any time.

A participant’s and his or her dependent coverage can terminate on the earliest of:

- The day the participant terminates employment,
- The day the participant ceases to be in an eligible class of employees,
- The day the participant fails to make any required contributions to the Plan, or
- The day the participant’s employer discontinues the Plan.

If coverage is due to terminate because of the participant’s death, coverage for dependents will continue until the earliest of:

- The day required contributions are not made,
- The day the dependent no longer qualifies as a dependent, or
- The day the surviving spouse remarries or dies except as provided by law.

A dependent’s coverage can terminate on the day the dependent no longer qualifies as an eligible dependent. A dependent that is physically or mentally incapable of self-support may continue coverage during the period the dependent remains incapacitated and unmarried as long as:

- The dependent continues to be covered by the Plan,
- Proof of incapacity is received within 31 days after coverage would otherwise terminate and at any other time required, and
- The dependent’s condition of incapacity is approved by PURMS.

NOTE: Your rights to postretirement benefits are subject to the policies of your employer and can change at any time.

Can dental benefits be continued if a person is enrolled in this coverage and becomes ineligible for it?

Yes. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), all employees and their qualified beneficiaries covered under an employer’s health plan have the right to elect to temporarily continue their coverage under the plan if it would end due to certain events, which are known as “qualifying events”. Please refer to **COBRA** in the **General Information Section** for more information.

If continued coverage is offered to retirees by your employer, employees terminating employment after age 55 and directors leaving the board at any age are eligible to continue coverage for themselves and their dependents as long as they were covered at the time of the termination or retirement. **NOTE:** Your rights to postretirement benefits are subject to the policies of your employer and can change at any time.

The Administrator will be able to provide you with information on options available to you and the forms necessary to continue your coverage.

Schedule of Benefits

Dental Benefit Plan

DEDUCTIBLE

Annual deductible \$50

MAXIMUM BENEFITS

Annual maximum benefit per person \$2,000 per person

Maximum benefit per service Reasonable and customary charges

PREVENTIVE AND DIAGNOSTIC SERVICES 100% reasonable and customary charges
for covered services

BASIC SERVICES 80% of reasonable and customary charges for covered services.

MAJOR SERVICES 50% of reasonable and customary charges for covered services, after deductible.

ORTHODONTIA

Eligible participants Employee, spouse, eligible children

Orthodontic lifetime benefit per person \$2,000 per person

Orthodontic services 50% of covered services, no deductible.

Eligibility

Who is eligible?

- Eligible employees, unless excluded by job classification, and their eligible dependents
- Retirees and their eligible dependents
- Directors, one retained attorney and their eligible dependents

Please refer to **Eligibility and Participation** in the **General Information Section** in the front of this Summary Plan Description for more information.

When may I enroll?

When you are hired as an eligible employee, you may enroll yourself, and if applicable, your eligible dependents. After you enroll, your coverage will begin when you complete the eligibility-waiting period.

If you or your dependent is confined for medical care or treatment in any institution or at home on the date coverage would otherwise become effective, the coverage will be delayed until the effective date of the final medical release from the confinement.

If you are not working on the day you would ordinarily become covered, the coverage for you and your dependents (if applicable) will be delayed until you return to work. This is the Active Work Requirement provision.

Director and their eligible dependents do not have to satisfy a waiting period. They have 31 days from the date of their election to the board or the date they attend their first board meeting, whichever is later, to sign their application.

When is the eligibility waiting period?

The eligibility waiting period is the length of time that you must work before you are eligible to be covered by the dental program.

There is no waiting period. When you are hired as an eligible employee, you may enroll and you will become covered on the day you begin work at the employer, or at any location to which the employer's business requires you to travel.

What happens if I don't enroll when I first become eligible?

If you do not enroll within 31 days after you are eligible, your coverage will be limited for the first year of your enrollment. During the first year of your enrollment, the Dental Expense Benefit for you and your dependents age five or over **will not** be applicable to "Major" services as listed in the section **List of Dental Services: Major Services**. Note that these lists appear on later pages in this Summary Plan Description. This exclusion does not apply if you need major dental services because of an accident occurring while covered, provided you are covered by a medical benefit plan sponsored by PURMS.

Coverage

How much does the Plan pay for preventive and diagnostic services?

The Plan pays 100% of the reasonable and customary charge for preventive and diagnostic services that are incurred while you and each dependent are covered.

How much does the Plan pay for basic services?

The Plan pays 80% of the reasonable and customary eligible charges for basic services that are incurred by you and each covered dependent.

How much does the Plan pay for major services?

After you or a covered dependent satisfies the annual deductible described next, your Dental Expense Benefit coverage will pay 50% of the reasonable and customary charge for eligible major services, incurred during the rest of the calendar year.

How much is the annual deductible?

The annual deductible is the first \$50 of eligible major dental charges incurred by you or your dependent during a **calendar year**. Each individual must satisfy the deductible each **calendar year**.

How much is the maximum annual dental benefit amount?

The maximum annual dental benefit amount of all services is \$2,000 each calendar year for you or for each dependent.

How much does the orthodontic expense benefit pay under this Plan?

The orthodontic expense benefit pays 50% of the eligible charges for you and your dependents. This benefit is in addition to the yearly maximum for the Dental Expense Benefit.

How much is the maximum lifetime orthodontic benefit amount?

The maximum lifetime orthodontic benefit amount is \$2,000.

Dental Treatment Plan

What is a dental “treatment plan”?

Dental charges for you or a covered dependent are eligible only when the dentist has submitted a proposed course of treatment. The proposed course of treatment is called a dental treatment plan. It must be submitted to the Administrator. The Administrator then returns the plan to the dentist showing the estimated benefits. If the total charges are less than \$300, or if emergency care is required, a “treatment plan” does not need to be submitted.

In computing estimated benefits, the Administrator may consider alternate dental services that are suitable for the treatment of a specific condition. This will be done only if these alternate services would produce a professionally acceptable result as determined by the Administrator.

What is contained in a “treatment plan”?

- 1) A “treatment plan” is the dentist’s report that itemizes his or her recommended services,
- 2) Shows his or her charge for each service, and
- 3) Is accompanied by supporting x-rays or any other necessary documentation where required or requested by the Administrator.

What is the purpose of predetermination of benefits?

Predetermination of benefits gives the Administrator the chance to review the proposed treatment in Advance and allows for resolution of any questions before, rather than after, the work Has been done, and charges incurred. This way, both you and the dentist will know in Advance what is covered and what the estimated benefits are.

Eligible Charge

What is an “eligible charge”?

An “eligible charge” is one the dentist makes for a covered preventive, diagnostic, basic or major dental service furnished to you or your covered dependent. The service must be:

- 1) In the list of dental services;
- 2) Part of a treatment plan as described above; and
- 3) Not excluded by the section **Exclusions under the Dental Expense Benefit.**

What is the amount of the eligible charge?

The amount of the eligible charge for a service is equal to the charge made by the dentist, not to exceed the reasonable and customary (R&C) charge. For a definition of R&C, refer to the **Definitions for the Purpose of the Plan** within the **General Information Section.**

When is a charge considered to be incurred?

A charge will be considered to be incurred:

- 1) For an appliance, or modification of an appliance – on the date the impression is taken.

- 2) For a crown, bridge or gold restoration – on the date the tooth is prepared.
- 3) For a root canal therapy – on the date the pulp chamber is opened.
- 4) For all other services – on the date the service is received.

Can I choose my own dentist?

You may choose any licensed dentist or any doctor who is licensed to provide dental services.

If I have a dental condition that my dentist can treat in several ways, and my dentist chooses one of the more expensive treatments, will it be covered?

Many dental conditions can properly be treated in more than one way. Your coverage is designed to help pay dental expenses, but not on the basis of treatment that is more expensive than necessary for good dental care.

Thus, if a condition is being treated, and there are two or more services included in the list that are suitable under customary dental practices, then the benefit will be based on the listed service that, according to the Administrator, would produce a professionally satisfactory result.

To demonstrate the application of the above provision, take two examples involving treatment of cavities in several front teeth.

First example: It is determined that fillings would produce a professionally satisfactory result, but the patient decides to have the teeth crowned for the sake of appearance as the teeth are stained due to smoking. Here, the benefit would be based on the amount that would be provided for fillings.

Second example: It is determined that, because of the condition of the teeth, crowns rather than fillings are required for a professionally satisfactory result. Here the benefit would be based on the use of crowns.

If a dental service is performed that isn't on the list, but the list contains one or more other services that under customary dental practices are suitable for the condition being treated, then for the purpose of the Plan the listed service that the Administrator determines would produce a professionally satisfactory result will be considered to have been performed.

List of Dental Services

Preventive and Diagnostic Services

Visits and Examinations

- Visit during office hours for oral examination (not more than two visits per year)
- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Special consultation by a specialist for case presentation when diagnostic procedures have been performed by a general dentist
- Emergency palliative treatment, per visit
- Prophylaxis (teeth cleaning) for children under age 14 limited to two every year
- Prophylaxis (teeth cleaning) for individuals age 14 and over limited to two every year (including scaling and polishing)
- Topical application of fluorides including prophylaxis (limited to one course of treatment per year, and to children under 18)

X-Rays and Pathology

- Bitewings (not more than twice every year) – 2 films, 4 films
- Entire denture series – 14 or more films including bitewings, if necessary (limited to once every 3 years)
- Panorex – one single film of full mouth (limited to once every 3 years)
- Single films; additional films (up to 12), each
- Intraoral, occlusal view, maxillary or mandibular, each
- Upper or lower jaw, extraoral – 1 film, 2 films
- Biopsy and examination of oral tissue
- Microscopic examination
- Diagnostic casts – study model

Sealants – limited to children under age 19, to permanent molar teeth and to two applications separated by a period of not less than 48 hours.

Basic Services

Restorations (fillings) – multiple restorations in one surface will be considered as a single restoration

- Amalgam (primary, permanent teeth) – cavities involving 1 surface, 2 surfaces or 3 or more surfaces
- Silicate cement
- Plastic
- Composite – cavities involving 1 surface, 2 surfaces or 3 or more surfaces
- Pins (retention) where part of the restoration used is instead of gold or crown restoration

Restorative repairs

- Denture Repairs
 - Full and partial denture repairs
 - Broken denture, no teeth involved
 - Partial denture repairs (metal)
 - Replacing missing or broken teeth, each tooth
- Adding teeth to partial denture to replace extracted natural teeth
 - First Tooth
 - First tooth with clasp
 - Each additional tooth and clasp
- Recementation of inlay, crown, bridge
- Repairs of crown and bridges

Space maintainers – includes all adjustment with six months after installation

- Fixed space maintainer (brand name)
- Removable acrylic and round wire rest only

- Removable inhibiting appliance to correct thumb sucking

Oral Surgery – local anesthesia and routine postoperative care

- Extractions (pulling a tooth)
 - Uncomplicated extractions
 - Surgical extraction of erupted tooth
 - Surgical extraction of impacted tooth – soft tissue, partially bony, completely bony
 - Postoperative visits (sutures and complications) after multiple extractions and impaction
- Alveolar or gingival reconstructions
 - Alveolectomy (edentulous) per quadrant
 - Alveolectomy (in addition to removal of teeth) per quadrant
 - Alveoplasty with ridge extension, per arch
 - Excision of hyperplastic tissue, per arch
 - Excision of pericoronal gingival
- Cysts and neoplasms
 - Incision and drainage of abscess
 - Removal of cyst or tumor up to 1.25 cm
 - Removal of cyst or tumor over 1.25 cm
- Other surgical procedures
 - Removal of salivary calculus
 - Closure of salivary fistula
 - Dilation of salivary duct
 - Transplantation of tooth or tooth bud
 - Removal of foreign body from bone (independent procedure)
 - Maxillary sinusotomy for removal of tooth fragment or foreign body
 - Closure of oral fistula of maxillary sinus
 - Sequestrectomy for osteomyelitis or bone abscess, superficial
 - Condylectomy of temporomandibular joint
 - Meniscectomy of temporomandibular joint
 - Radial resection of mandible with bone graft
 - Crown exposure to aid eruption
 - Removal of foreign body from soft tissue
 - Frenectomy
 - Suture of soft tissue injury
 - Injection of sclerosing agent into temporomandibular joint

Treatment of trigeminal neuralgia by injection into second and third divisions

- Antibiotic injections administered by the treating dentist.

General anesthesia – only when provided in conjunction with a surgical procedure

Periodontics

- Emergency treatment (periodontal abscess, acute periodontitis, etc)
- Subgingival curettage or root planing and scaling, per quadrant (limited to 4 quadrants of each) per year
- Correction of occlusion related to periodontal surgery, per quadrant
- Gingivectomy (including post-surgical visits) per quadrant
- Gingivectomy, osseous or muco-gingiva surgery (including post-surgical visits) per quadrant
- Gingivectomy, treatment per tooth (fewer than 6 teeth)

Endodontics – unless otherwise indicated, the limit shown is for one tooth

- Pulp capping
- Therapeutic pulpotomy – in addition to restoration
- Vital pulpotomy
- Remineralization (Calcium hydroxide, temporary restoration) as a separate procedure only
- Root canals (devitalized teeth only, including necessary x-rays & cultures, but excluding final restoration

Single rooted can therapy (traditional method)

Single rooted can therapy (Sargenti method)

Bi-rooted can therapy (traditional method)

Bi-rooted can therapy (Sargenti method)

Tri-rooted canal therapy (traditional method)

Tri-rooted canal therapy (Sargenti method)

Apicoectomy, including filling a root canal

Apicoectomy (separate procedure)

Major Services

Gold restorations and crowns are covered only as treatment for decay or traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a covered partial denture or fixed bridge.

Inlays

One surface

Two surfaces

Three or more surfaces

Onlay, in addition to inlay allowance

Crowns

Acrylic

Acrylic with gold

Acrylic with non-precious metal

Porcelain

Porcelain with gold

Porcelain with non-precious metal

Non-precious metal (full cast)

Gold (full cast)

Gold (3/4 cast)

Gold dowel pin

Stainless steel

Bridge Abutments (see inlays and crowns)

Pontics (artificial teeth)

Cast gold (sanitary)

Cast non-precious metal

Slotted facing (Steele's)

Slotted pontic (Tru-pontic type)

Porcelain fused to gold

Porcelain fused to non-precious metal

Plastic processed to gold

Plastic processed to non-precious metal.

Removable bridge (unilateral)

One piece casting, gold or chrome cobalt alloy clasp attachment (all types), per unit including pontics.

Dentures and partials

Fees for dentures, partial dentures and relining include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.

Complete upper and lower dentures

Partial acrylic upper or lower with chrome cobalt alloy clasps, base, all teeth and 2 clasps

Each additional clasp

Partial lower or upper with chrome cobalt alloy lingual or palatal bar and acrylic saddles, base, all teeth and 2 clasps

Each additional clasp

Simple stress breakers, extra

Stayplate, base

Each additional clasp
Office reline, cold cure, acrylic
Laboratory reline
Special tissue conditioning, per denture
Denture duplication (jump case), per denture
Adjustments to denture more than 6 months after installation

Orthodontic Expense Benefit

What is the Orthodontic Expense Benefit?

This coverage applies to orthodontic treatment (a program to straighten teeth) when you and your dependents are covered under the Dental Expense Benefit.

What does my dental plan pay?

Your plan pays 50% of the eligible charges incurred. The maximum lifetime orthodontic benefit is \$2,000 per person.

Eligible Orthodontic Charges

What are eligible orthodontic charges?

Eligible charges are those made to you for an orthodontic procedure that:

- 1) is in an “orthodontic treatment plan” that **prior to the treatment** has been reviewed by the Administrator and returned to the dentist showing estimated benefits, and
- 2) is required by an overbite of at least four millimeters, crossbite, or protrusive or retrusive relationship of at least one cusp.

Orthodontic Treatment Plan

What is an “orthodontic treatment plan”?

An orthodontic treatment plan is a report on a form satisfactory to the Administrator that describes the recommended treatment, gives the estimated charge, and is accompanied by cephalometric X-rays, study models and other supporting evidence.

When are charges considered to be incurred?

Charges will be considered to be incurred on the date of the orthodontic appliances are first inserted. Initial banding fee will be paid on the date the Administrator is notified bands have been placed. The remaining program balance will be paid in equal quarterly installments over the estimated duration of the treatment program, not to exceed 24 months.

Dental expense Benefit Exclusions

In the case of an individual whose Dental Expense Benefit coverage starts more than 31 days after that individual becomes eligible, the services received during the first year the coverage is in effect will be limited. During the first year the coverage is in effect, the Dental Expense Benefit **will not** be applicable to “Major” services as listed in the section, **List of Dental Services** (“Major Services”). That means that you or your dentist will not be able to receive payment from the Administrator for dental expenses listed as “Major Expenses”. This exclusion does not apply if major dental services are needed because of an accident occurring while the individual is covered, provided the individual is covered by a medical benefit plan sponsored by PURMS.

In addition to the Plan’s general exclusions, the dental plan does not cover:

- 1) A service or supply not included in the **List of Dental Services** except under the conditions explained in “What the Benefit Covers”.
- 2) Anything not furnished by a dentist, except x-rays ordered by a dentist, and services by a licensed dental hygienist under the dentist’s supervision; anything not necessary or not customarily provided for dental care.
- 3) Services (a) furnished by or for the U.S. Government or any other government unless payment is legally required, or (b) to the extent provided under any law or governmental plan under which the individual is, or could be, covered. Item (b) does not apply to a state plan under Medicaid or any law or plan when, by law, its benefits are excess to those of any non-governmental program.
- 4) An appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or gold restoration for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered.
- 5) A crown, gold restoration, or a denture or fixed bridge or addition of teeth to one, if the work involves a replacement or modification of a crown, gold restoration, denture or bridge installed less than five years before.
- 6) A denture or fixed bridge involving replacement of teeth missing before the individual was covered, unless it also replaces a tooth that is extracted while covered, and such tooth was not an abutment for a denture or fixed bridge installed during the preceding five year.
- 7) Services due to an accident related to employment or disease covered under workers’ compensation or similar law.
- 8) Replacement of lost or stolen appliances.
- 9) Any portion of a charge for a service in excess of the reasonable and customary charge (the charge usually made by the provider, not to exceed the prevailing charge in the area for dental care of a comparable nature, by a person of similar training and experience).
- 10) Expenses applied toward satisfaction of a deductible under the Dental Expense Benefit.
- 11) Implants
- 12) Appliances or restorations for the purpose of splinting, or to increase vertical dimension or restore occlusion, or due to erosion or attrition.
- 13) Services for cosmetic purposes unless made necessary by an accident occurring while covered. Facings on molar crowns or pontics are always considered cosmetic.
- 14) Phase I & II treatment of temporomandibular joint (joint between skull and lower jaw). This includes diagnostic and splint therapy or any other treatment not involving the teeth.
- 15) Services rendered by a close relative.
- 16) Orthodontics (a program to straighten teeth), unless an orthodontic option is included in your dental coverage.

If a particular charge is covered under the Dental Expense Benefit and also under another part of our Benefit Plan, or any other plans of which we have paid any part of the cost, the Dental Expense Benefit will be limited to the difference, if any, between the amount normally paid by this benefit and the amount payable by the other plans.

Also see **Generally Excluded Charges, Definitions for the Purpose of the Plan and Coordination with Other Medical Plans** in the **General Information Section** in the front of this Summary Plan Description.

Exclusions Orthodontic Expense Benefit

Which charges are not covered?

The following charges are not covered:

- 1) Charges for a procedure, which an active appliance was installed before you, were covered (or installed before the patient was covered for two years, if coverage started more than 31 days after the patient was first eligible to be covered).
- 2) The charges referred to in **Exclusions under the Dental Expense Benefit**.
- 3) A charge incurred while the patient's coverage is not in effect.
- 4) A charge that doesn't meet the requirements as determined by the Administrator.

Also see **Generally Excluded Charges, Definitions for the Purpose of the Plan and Coordination with Other Medical Plans** in the **General Information Section** in the front of this Summary Plan Description.

How To File A Claim – All Claims

How do I file a claim?

- 1) If you or a covered dependent goes to the hospital, ask the hospital admissions clerk to contact the Administrator.
- 2) If you plan to accumulate medical or dental bills and submit them at a later date, keep a separate record of the medical expenses for yourself and each covered dependent. This will help you when you are ready to make a claim. Save all medical bills, including those being accumulated to satisfy a deductible. In most instances, they will serve as evidence of your claim.

Accumulated medical and dental bills should show:

- a) Insured's full name and social security number.
- b) Patient's full name and social security number.
- c) Date or dates the service was rendered or purchase was made.
- d) Nature of the sickness or injury.
- e) Type of service or supply furnished
- f) Itemized charges.

Is there a claim-filing time limit?

All medical claims relating to payment for a benefit covered by the Plan must be filed within the 12-month period following the date the service is rendered. A claim form will not be considered filed until all required information related to the service or benefit for the claim has been provided to the Administrator.

Where can I get additional information?

The Administrator will be able to help you obtain more information on how to submit claims and how to appeal them if one should be denied.

APPEAL OF A CLAIM DENIAL – ALL CLAIMS

The complete Appeal Procedures are in the Self-Insurance Agreement available at the Company office.

If there are any questions about a claim payment, the Administrator should be contacted. If it is desired to initiate an Appeal Procedure because there is a disagreement with the reasons why the claim was denied, the Administrator should be notified in writing. A request for a review of the claim and examination of any pertinent documents may be made by the claimant or anyone authorized to act on his or her behalf. The reasons why it is believed that the claim should not have been denied, as well as any data, questions or appropriate comments, should be submitted in writing.

The responsibility for full or final determinations of eligibility for benefits; interpretation of terms; determinations of claim; and appeals of claim denied in whole or in part under the Plan rests exclusively with the Administrator.

CUSTOMER SERVICE DIRECTORY

Administrator:

Richard (Dick) Rodruck - 1.800.562.5226

Claims Consultant:

Diane Christensen - 1.800.562.5226

Coverage Questions:

Diane Christensen - 1.800.562.5226

Bambi Harrison - 1.800.562.5226

Ryan VanAckeren - 1.800.562.5226

Eligibility:

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Ryan VanAckeren - 1.800.562.5226

Diane Christensen - 1.800.562.5226

Correspondence and Claim Filing Address:

Pacific Underwriters

P.O. Box 66040

Seattle, WA 98166

Telephone for all questions regarding coverage and claims:

1.800.562.5226



Administrator