

JEFFERSON COUNTY PUD

Health And Welfare Benefit Booklet

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GROUP COVERAGE AT A GLANCE

This “coverage at a glance” is a general overview. Your Company through the Public Utility Risk Management Services (PURMS) Self-Insurance Fund provides the Plan described in this booklet. The Plan is administered by Pacific Underwriters. The Coverages, benefits and amounts described may be changed at a later date. Any Change in your and your dependent’s benefits, class or status will take effect only when all of the Plan terms have been met.

PLAN EFFECTIVE DATE

The Plan Effective Date is April 1, 2000.

Prescription Drug Coverage

Copay per Prescription or Refill

For a generic drug or medication and for brand name drug or medication for which no generic equivalent is available	\$10
For any other drug or medication	\$20

Major Medical Coverage

Yearly Deductible

Per Person	\$125
Per Family Unit	\$375
Maximum Benefit – Per injury or sickness	\$2,000,000

Under certain circumstances the amount of Hospital Expenses that will be considered as Covered Expenses will be reduced. Refer to the Major Medical Coverage Section for details.

Additional Major Medical Benefits

Maximum Benefit for Second Surgical Consultation	\$100
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Dental Coverage

Preventative Services:	
Co-payment	80%
Basic Services	
Co-payment	80%
Major Services:	
Co-payment	50%
Yearly Deductible	\$50
(Applies to basic Services and Major Services)	
Maximum of 2 Deductibles per family per year	
Maximum Benefit Per Year – Per Person	\$1,000

If the person's coverage starts more than 31 days after his or her eligibility date, the maximum benefit payable for all Covered Dental Services incurred during his or her first Benefit Year is \$150.	
Orthodontic Coverage	
Orthodontic Services	
Co-payment	50%
Lifetime Maximum Benefit	\$500 per person

SOME TERMS YOU SHOULD KNOW

You and your means you, the employee.

We, us, our and ours mean Jefferson County PUD.

Administrator means Pacific Underwriters.

Fund means the PURMS Self-Insurance Fund.

Insured or Covered Person means you or a dependent of yours while covered under this Plan.

Family Unit means you and your covered dependents.

Company means Jefferson County PUD.

A year is a calendar year running from January 1 through December 31.

Medicare means the benefits of the XVIII of the Social Security Act of 1965, and all amendments to it.

Active, full-time work means doing the normal duties of your job at least 20 hours a week on a regular basis. This does not include time you work at home or while confined in a Hospital or similar place.

INCONTESTABILITY WITH RESPECT TO THE COMPANY'S BENEFIT PLAN

No statement made by the Company or by a covered person relating to eligibility or insurability under the Plan will be used in contesting the validity of that Company's Benefit Plan after that Plan has been in force under the Plan for 2 years prior to the contest or unless:

1. the statement is in writing and signed by the Company or by the covered person; and
2. a copy of that statement is or has been given to the Company.

INCONTESTABILITY WITH RESPECT TO COVERED PERSONS

No statement made by any person covered under the Plan relating to his or her good health will be used in contesting the validity of the coverage with respect to which that statement was made unless:

1. the statement is in writing and signed by that person; and
2. a copy of that statement is or has been given to that person or to his or her beneficiary.

CLERICAL ERROR

A clerical error on the part of the Company or the Administrator will not:

1. deprive a person of the insurance he or she is entitled to under the Plan; not
2. cause insurance to continue beyond the date on which it would reduce or end.

However, none of the following will be considered to be a clerical error:

- the Administrator does not receive an application for insurance to take effect or increase; or
- the Administrator is not notified of a change in a covered person's benefit class which would otherwise have qualified that person for an increase in benefits under the Company's Benefit Plan.

Coverage in such circumstances shall extend only to that which the Administrator has approved in accordance with the provisions of the Plan.

HOW TO BECOME COVERED

WHO IS ELIGIBLE, AND WHEN

You are eligible under this Plan if you are a full-time employee of ours other than a seasonal employee.

You are eligible on the later of: (a) the first day of the month that falls on or next after the date you become a full-time employee, or (b) the Plan Effective Date.

To be a full-time employee, you must be on a 20 or more hour work week schedule on a regular basis with us. This does not include time you work at home, or while confined in a Hospital or similar place. Part-time, temporary, or substitute employees are not eligible.

HOW TO APPLY

In order for your coverage to start, you must first apply for it.

To apply, just complete an enrollment form no later than 31 days after your eligibility date and return it to us.

WHEN YOUR COVERAGE STARTS

Subject to the Special Requirements shown below, your coverage will start on the first day of the month that falls on or next after the latest of these dates:

1. If the Company requires proof, the date the Company approves your application.
2. If the Company does not require proof, your date of employment as a full-time employee.

You must be at active, full-time work for us in order for your coverage to start. If you are not, your coverage will start on the date you come back to active, full-time work. "Active, full-time work" means doing the normal duties of your job. This does not include time you work at home, or while confined in a Hospital or similar place.)

Special Requirements

1. This Special Requirement applies to you if:
 - a. you must prove that you are in good health in order for your coverage to start; and
 - b. you must cease to be eligible for the coverage before you give that proof.

In this case, you will still have to provide proof if you again become eligible and apply for coverage. Your coverage will start on the first day of the month that falls on or next after the date proof of your good health is approved. (You must provide this proof at your own expense.)

WHO ARE ELIGIBLE DEPENDENTS

Except as stated below, your dependents who may become eligible under this Plan are:

- your spouse;
- your unmarried children under age 19; and
- your unmarried children age 19 but under age 26 who are full-time students at an accredited school or college and fully supported by you. "Full-time student" means full-time as defined by the rules of the school or college.

The term "children" means:

- your natural children

- your adopted children; and
- any other children who live with you in a parent-child relationship, and who depend on you for their full support.

No person who is eligible as an employee under this Plan may be eligible as a dependent. Also, a person may not be a dependent of more than one employee.

No spouse or child who is on active military duty may be eligible as a dependent.

WHEN DEPENDENTS BECOME ELIGIBLE

A dependent becomes eligible on the latest of these dates (but not before the Plan Effective Date or the date you are in a class eligible for Dependent Coverage:

1. The date he or she becomes a dependent of yours;
2. In the case of a newborn child:
 - Under the other Dependents Coverages, the date of birth; or
 - in the case of a newly adopted child, the date the child is placed with you pending final adoption. Such a child will remain eligible unless the adoption process stops, and the child is removed from placement with you.

This is the dependent's eligibility date.

HOW TO APPLY FOR DEPENDENT COVERAGE

In order for a Dependent's Coverage to start, you must first apply for it.

If you apply more than 31 days after the date you first have a eligible dependent, proof that each dependent you have is in good health will be required. (You must provide this proof at your own expense.)

Addition of Dependents

Even if you have Dependent Coverage, you still have to apply in order for any new dependent to become covered.

Exception for a Newborn or Newly Adopted Child

If you already have Dependent Coverage, your newborn child will be covered immediately from the date of birth for 31 days; and your adoptive child will be covered immediately from the date he or she is placed with you pending final adoption, for 31 days. You must apply for coverage and pay the required premium, if any, within 31 days after the date of birth or adoptive placement in order for the coverage to continue beyond this 31-day period.

Coverage is provided for treatment of injury, sickness, birth defects and extra medical care needed as a result of premature birth.

Coverage is also provided for these charges made for the routine care of a newborn child received before the child leaves the Hospital in which he or she was born: (a) Hospital nursery charges; (b) charges for routine tests and doctors' examinations; (c) charges for circumcision. But we do not cover any routine care of the child once he or she has left the Hospital.

Exception for Court Order Child Coverage

If you receive a court or administrative order to provide coverage for an eligible child not currently enrolled, you may apply for coverage within 31 days of receipt of the court or administrative order. You must provide us with a copy of the court or administrative order. If you fail to apply as ordered, the child's other parent or legal

custodian, or the state's Medicaid agency may apply for the coverage. You may not stop coverage for such a child under this Plan unless you provide us with written evidence that:

1. The court or administrative order is no longer in effect; or
2. The child is enrolled in similar health care coverage; or
3. We have eliminated family health coverage for all employees.

WHEN DEPENDENTS COVERAGE STARTS

1. Coverage for a dependent who is eligible on the Plan Effective Date will start on the latest of these dates:
 - The Plan Effective Date, if you apply for Dependent Coverage on or before that date. If not, then the first day of the month that falls on or next after the date you do apply.
 - The date your own coverage which provides similar Coverage starts (or the date your coverage would have started, except that you elected Medicare to be your primary coverage. This applies when federal law requires Medicare to pay its benefits after this Plan, but allows you to choose Medicare as your primary coverage.)
 - The first day of the month that falls on or next after the date proof of that dependent's good health is approved.
 - In the case of a dependent (other than a newborn child or newly adopted child) who is confined in a hospital or similar place, or at home in lieu of Hospitalization on the date his or her coverage would take effect, the first day of the month that falls on or next after the date of his or her final discharge.
2. Coverage for any other dependent will start on the latest of these dates:
 - The first day of the month that falls on or next after his or her eligibility date.
 - The first day of the month that falls on or next after the date you apply for Dependents Coverage.
 - The date your own coverage that provides similar Coverage starts (or the date your coverage would have started, except that you elected Medicare to be your primary coverage. This applies when federal law requires Medicare to pay its benefits after this Plan, but allows you to choose Medicare as your primary coverage.
 - The first day of the month that falls on or next after the date any required proof of that dependent's good health is approved.
 - If any of the Special Requirements shown below apply, the date that requirement is met.
 - In the case of a dependent (other than a newborn child or newly adopted child) who is confined in a hospital or similar place, or at home in lieu of Hospitalization on the date his or her coverage would take effect, the first day of the month that falls on or next after the date of his or her final discharge.

Special Requirements

1. This Special Requirement applies to a dependent who:
 - must prove that he or she is in good health in order for coverage to start; and
 - ceases to be eligible for the coverage before that proof is given.

In this case, you will still have to give that proof if the dependent again becomes eligible and applies for coverage. His or her coverage will start on the first day of the month that falls on or next after the date that proof of good health is approved. (You must provide this proof at your own expenses.)

CHANGES IN A DEPENDENT'S COVERAGE

Any increase in a dependent's insurance amounts or coverage will take effect on the latest of these dates:

- The first day of the month that falls on or next after the date the Administrator approves your dependent's proof of good health, if such proof is required by then current underwriting standards;
- The first day of the month that falls on or next after the effective date of the charge;

- The date of similar change in your coverage takes effect;
- In the case of a dependent who is confined in a Hospital or similar place, or at home in lieu of Hospitalization on the date the increase would take effect, the first day of the month that falls on or next after the date of his or her final discharge from the facility or home care program.

Any decrease in a dependent's insurance amounts or coverage will take effect on the first day of the month that falls on or next after the effective date of the change.

GENERAL INFORMATION ABOUT YOUR HEALTH CARE COVERAGES

Health care coverage is designed to help you pay for your and your family's health care expenses. Many kinds of expenses you have in connection with hospital, surgical, medical and dental care are covered. Some are not.

The Health Care Coverages provided under this Plan are described in the following Sections. In each of these Sections we tell you which expenses are paid for under that Coverage and how much of each expense are paid. We also tell you which expenses are not covered.

In the **Coordination of Health Care Benefits** Section, we tell you how these benefits are paid when you are entitled to benefits from Medicare, other insurance plans and other sources of payment. Because federal law has many different rules, we may not always coordinate with Medicare. Sometimes Medicare will pay first and we will coordinate with its benefits. At other times, we must pay our benefits before Medicare.

Before any benefits are paid under a coverage the Administrator must receive proof that all requirements of that Coverage have been met. In the **How To File A Claim** Section, we tell you how to make a claim for benefits.

The Health Care Coverage provided under this Plan is designed to encourage you to join in the effort to control health care costs. You can help by using Preferred Provider Organization (PPO) health care providers when you are injured or sick. The health care providers have joined together to control health care costs and still give you quality health care. We tell you how much are paid for the services of a PPO provider in the following sections. Under this Plan, you do not have to go to a PPO health care provider. For example, you may go to any PPO doctor listed in the directory you receive, to your family doctor, or health care provider, you may save on out-of-pocket expenses without giving up your freedom to choose providers or the quality of care you receive.

You may choose the PPO health care providers only if they are available in your area.

DEFINITIONS

Here are some basic terms that you should know. We use these terms when we describe your health care Coverages.

Doctor means:

1. A legally qualified physician licensed to practice medicine and perform surgery.
2. Any other duly licensed practitioner of the healing arts if:
 - a. We are required by the law of the proper governmental authority to recognize that person; and
 - b. that person provides services that are within the scope of his or her license and which are covered by this Plan.

An expense is incurred at the time the medical or dental care is received.

Provider means a person or institution who or which provides care to a covered person.

An expense is **reasonable** if, in the Administrator's judgment, the charge is the usual and customary charge for that attention or care in the locale where it is received. If the Administrator cannot determine the usual and customary charge for the attention or care because there are not enough providers of that attention or care in the locale to establish a prevailing charge, the Administrator will calculate the reasonable charge for it based on:

- the complexity of the attention or care; and
- the degree of professional skill needed to provide it; and
- other pertinent factors.

Any amount a Non-Network Provider charges for Medical Care that is more than the Administrator consider reasonable as defined above, is not a Covered Expense.

Medical Care means necessary services, supplies, diagnosis, treatment, drugs and medicines provided for the care of treatment of an injury or a sickness or a pregnancy. A service, supply, diagnosis, treatment, drug or medicine is necessary if it is recognized by the organization which establishes standards for the provider as being appropriate, effective and essential for the care of treatment of the injury, sickness or pregnancy. But expenses for the following Medical Care will not be considered necessary:

- that provided as an in-patient, if the care or treatment of the injury, sickness or pregnancy could safely and adequately have been provided on an out-patient basis; or
- that provided mainly for the personal comfort or convenience of the covered person; or
- that part of the Medical Care for which the cost is more than any other Medical Care which could safely and adequately have treated the injury, sickness or pregnancy; or
- that which is experimental, investigative, developmental or educational in nature, or which is not generally recognized by the organization which establishes standards for the provider as beneficial for the care or treatment of the injury, sickness or pregnancy.

Psychiatric and Substance Abuse Care means treatment of a mental or nervous disorder, or substance abuse.

Substance Abuse means the abuse of, psychological or physical dependence on, or addiction to alcohol, toxic inhalants or a controlled substance.

Toxic Inhalant means a volatile chemical, abusable glue or aerosol paint.

Partial Hospitalization means care provided for at least 3 hours, but less than 12 hours in any 24-hour period at a Hospital, and without which the covered person would require in-patient care.

Injury means a bodily injury caused by an accident.

Sickness means a disorder, a disease or an illness. (Any type of hernia or strained back is considered a sickness rather than an injury.)

All injuries or sicknesses due to the same or a related cause are considered one injury or sickness.

Pregnancy is considered a sickness under your health care coverage. This means that it is covered just like a sickness. Pregnancy includes childbirth, abortion, miscarriage and complications arising from pregnancy.

A Complication of Pregnancy means these conditions which are distinct from but caused or affected by a pregnancy and which require treatment before the end of the pregnancy;

- acute nephritis or nephrosis; or
- cardiac decompensation or missed abortion; or
- a similar condition as severe as these.

Not included are: (a) false labor, occasional spotting, or doctor prescribed rest; (b) morning sickness; and (c) similar conditions not medically distinct from a difficult pregnancy.

A Complication of Pregnancy also includes:

- a non-elective Caesarian section; and
- termination of an ectopic pregnancy; and

- spontaneous termination when a live birth is not possible; and
- hyperemesis gravidarum and pre-eclampsia.

You are **totally disabled** when you are not able to work at all at any job or business for pay or profit due to injury or sickness. A dependent is totally disabled when he or she is not able at all to perform, due to injury or sickness, the normal daily activities of a person of like age and sex.

Year means a calendar year running from January 1 through December 31.

Hospital means a facility which meets all of these tests:

- it provides in-patient services for the care and treatment of injured and sick people; and
- it provides room and board services and graduate nursing services 24 hours a day; and
- it has established facilities for diagnostic x-ray and laboratory examinations and major surgery; and
- it is supervised by a doctor; and
- it is licensed as a Hospital under the laws of the jurisdiction in which it is located.

But a Hospital is not required to have major surgery facilities in the case of a confinement for alcoholism, drug addiction or any mental, nervous or emotional disorder.

A Hospital does not include: (a) a Convalescent Care Facility or similar place even if it is affiliated with a Hospital; (b) a clinic; (c) a nursing or rest home; or (d) a place run mainly for the care of the aged.

In-Patient means an admitted patient of a facility who needs its room and board services.

Out-patient means any patient of a facility who is not an in-patient.

Convalescent Care Facility means a properly licensed facility that meets all of these tests;

- it is mainly engaged in providing in-patient care for people recovering from injury or sickness; and
- it is supervised by a doctor or registered nurse; and
- it provides 24 hour per day nursing services and the emergency services of a doctor; and
- it keeps complete medical records on all patients; and
- it has transfer arrangements with a least one Hospital; and
- it has a utilization review plan and follows policies developed with the advice of a professional group (including at least one doctor) that also reviews those policies from time to time; and
- it requires that each patient be under a doctor's care; and
- it must not be a place mainly for; alcoholics, drug addicts or the mentally ill; tuberculosis or maternity patients; the aged, blind or deaf; or rest of custodial care.

Ambulatory Surgical Center means a properly licensed facility that meets all of these tests;

- it is equipped and operated mainly to perform surgery; and
- it has an organized staff of doctors and continuous medical and registered nursing services whenever a patient is there; and
- it keeps adequate medical records on all patients and has a utilization review plan; and
- it has transfer arrangements with at least one Hospital; and
- it does not provide accommodations for patients to stay overnight.

Birthing Center means a properly licensed facility that meets all of these tests:

- it is mainly engaged in providing care for childbirth, including prenatal and postpartum care; and

- it provides 24 hour a day nursing service by or under the supervision of registered graduate nurses (R.N.) and certified nurse midwives; and
- it requires that a doctor examine the patient at least once before delivery; and
- it requires only a doctor perform any surgical procedure; and
- it contains at least the following equipment, and has trained personnel to operate that equipment: (a) a fetal monitor; (b) an incubator; and (c) a resuscitator; and
- it does not keep any patient for more than 24 hours of in-patient treatment; and
- it has a written agreement in force with at least one Hospital for immediate transfer of patients who require treatment in a Hospital; and
- it keeps complete medical records on all patients; and
- it has a utilization review plan.

Hospice means a facility that provides a place to stay for short periods of time in a home-like setting for the covered person who has a terminal illness. These stays must be for direct care or rest from the symptoms of the terminal illness.

Hospice Care Services mean services and supplies to: (a) reduce or lessen pain or other symptoms of mental or physical distress; and (b) meet the needs that arise out of the stresses of a terminal illness, dying and bereavement. These services must be provided by a Hospice or a Hospice Team.

Hospice Care Program means a formal program of Hospice Care Services for the covered person who has a terminal illness. The Program must:

1. Be written and directed by a doctor;
2. Meet standards set by the National Hospice Organization; and
3. Be approved by us.

Hospice Team means a group of professional and volunteer workers. The group must include at least a doctor and a registered nurse (R.N.). It may include: a social worker, a clergyman or counselor; volunteers; a clinical psychologist; a physiotherapist; or an occupational therapist.

Negotiated fee means the amount that a Preferred Provider Organization (PPO) health care provider has agreed to charge for a service, treatment or supply provided to a covered person.

PRESCRIPTION DRUG COVERAGE

Refer to the **General Information About Your Health Care Coverages** Section to see how certain terms used in this Section are defined.

WHAT IS PRESCRIPTION DRUG COVERAGE?

Under this Coverage, are paid the benefits shown below if a covered person incurs necessary expenses for:

- a legend drug for which a written prescription is needed; or
- a compound medication of which at least one ingredient is a legend drug; or
- injectable insulin furnished on written prescription; or
- any other drug for which, under the state law which applies, a written prescription is needed.
- This includes oral contraceptives.

These expenses must be incurred for treatment of the covered person while he or she is covered under this Coverage.

THE BENEFITS

For each prescription or refill, the covered person must pay the first:

- \$10 for a generic drug or medication and for brand name drug or medication for which no generic equivalent is available; or
- \$20 for any other drug or medication.

This is the Co-pay.

Are paid 100% of the reasonable charge incurred for the prescription or refill in excess of the Co-pay. If the prescription allows substitution for a brand name drug or medication, we will pay up to the cost of a generic equivalent and apply the generic drug or medication co-pay.

A **generic drug or medication** is any multi-source product not produced by an original innovator or a licensee.

Under this Coverage, a charge is **reasonable** if it does not exceed the sum of:

1. the average wholesale price of the covered ingredients in the prescription (as determined by us);
2. the customary professional dispensing fee (as determined by us); and
3. any sales tax which applies.

EXPENSES WE DO NOT COVER

We do not pay benefits for:

1. Drugs or medications that may be obtained legally without a doctor's prescription (except insulin).
2. Any type of device, even if it is prescribed by a doctor. ("Device" means a therapeutic device, an artificial appliance, a syringe, a hypodermic needle, a support garment or any other similar device, regardless of how it is to be used. It also includes contraceptive devices.)
3. Immunization agents, biological sera, blood or blood plasma.
4. Drugs labeled: "Caution – limited by Federal law to investigational use", or experimental drugs, even if the covered person is charged for them.
5. Giving or injecting drugs or medications.
6. Any drug or medication which is to be taken or given, in whole or in part, while the covered person is a patient in any of these places: a hospital; rest home; sanitarium; extended care facility; convalescent hospital; nursing home; or a similar place which has a facility for dispensing pharmaceuticals on its premises.
7. Prescription refills in excess of the number the doctor specifies.
8. Any prescription refilled more than one year after its original date.
9. Any drug or medication which the covered person may obtain without charge under any government program, including Workers' Compensation. But this does not apply to covered persons who are not eligible for coverage under such a law.
10. Any drug or medication taken or given at the place where it is dispensed.
11. Any amount of a drug or medication which is in excess of: (a) a 90 day supply from a participating mail order pharmacy; or (b) a 30 day supply from any other pharmacy.
12. Any amount of a drug or medication which is more than the amount normally prescribed by the covered person's doctor.
13. Any drug or medication for the treatment of infertility.

MAJOR MEDICAL COVERAGE

Refer to the **General Information About Your Health Care Coverages** Section to see how certain terms used in this Section are defined.

WHAT IS MAJOR MEDICAL COVERAGE?

Under this Coverage, the benefits shown below are paid, if a covered person incurs Covered Expenses. These expenses must be incurred while he or she is covered under this Coverage. They must be incurred as a result of an injury or a sickness or a pregnancy.

“Covered Expenses” include many kinds of expenses you and your family have in connection with doctor visits and hospital stays. We list them later on in this Section.

THE BENEFITS

In most cases, after the yearly Deductible is met:

- 90% of the negotiated fee for Covered Expenses the covered person incurs for services provided by a PPO Provider. Once the covered person’s PPO Co-payment Limit of \$500.00 is reached, 100% of all other of the negotiated fees for these expenses that he or she incurs for the rest of the year; and
- 80% of Covered Expenses the covered person incurs for all other services. Once the covered person’s non-PPO Co-payment Limit of \$1,000 is reached, 100% of all other of these expenses that he or she incurs for the rest of the year.

Once a combined Co-payment Limit of \$1,000 is reached, 100% for most Covered Expenses for the rest of the year. The combined Co-payment Limit can be satisfied by the covered person paying \$1,000 of Covered Expenses for services provided by a PPO Provider, by a Provider who is not a member of the PPO network, or both.

“Co-payment Limit” means the amount of Covered Expenses, after the deductible is satisfied, that the covered person must pay for each year, before the rate paid becomes 100%.

1. After the Deductible, if any, benefits for Covered Expenses incurred for psychiatric and substance abuse care are limited as follows:
 - (a) In-Patient Care/Partial Hospitalization. Are paid up to a maximum of 30 days per year for care received while the covered person is an in-patient in a Hospital. Each day of covered in-patient care may be exchanged for 2 days of partial hospitalization.
 - (b) Outpatient Care. Are paid the following benefits:
 - Office Visits. Are paid 50% of the first \$80 charged for each out-patient office visit, up to 52 visits per year. This means that the most we will pay for each visit is \$40 (50% of \$80).
 - All other. Are paid 50% for all other out-patient Psychiatric and Substance Abuse Care during any covered person’s lifetime is \$25,000. This limit applies to in-patient and out-patient care combined.
 - (c) Lifetime Maximum. The maximum benefit paid for Psychiatric and Substance Abuse Care during any covered person’s lifetime is \$25,000. This limit applies to in-patient and out-patient care combined.

These limits apply to expenses for Psychiatric and Substance Abuse Care whether these expenses are incurred for services provided by a PPO Provider, by a Provider who is not a member of the PPO network, or both.

1. The Additional Benefits described in the next Section are treated differently.
 - We will pay 100% of Covered Expenses up to the amounts shown in that Section. Then we apply the Deductible and pay the rest of these expenses as described above.

- (These expenses, when paid at 100%, do not count toward the Deductible. Nor do they count toward the Co-payment Limit.)
2. The following expenses do not count toward the Co-payment Limit. And even when other expenses are paid at 100%, the percentage are paid for these expenses will not be increased:
- expenses for Psychiatric and Substance Abuse Care (including care received while an inpatient); and
 - expenses for private duty nursing; and
 - expenses incurred in connection with alcoholism, drug addiction or substance abuse while the covered person is an in-patient.

FAMILY BENEFIT

After the family Deductible is met, the Co-payment Limit for all family members is equal to 3 times:

- (a) the PPO Co-payment Limit shown in **THE BENEFITS** provision, for services provided by a PPO provider. Once the PPO Co-payment Limit is satisfied, we will pay 100% of the negotiated fee for these family expenses for the rest of the year (except as noted in the “Exceptions”); or
- (b) the non-PPO Co-payment Limit shown in **THE BENEFITS** provision, for all other services. Once the non-PPO Co-payment Limit is satisfied, we will pay 100% of these family expenses for the rest of the year (except as noted in the “Exceptions”).

Also, the combined Co-payment Limit for all family members is equal to 3 times the combined Co-payment Limit shown in **THE BENEFITS** provision. Once the combined Co-payment Limit has been satisfied, we will pay 100% of the family’s Covered Expenses for the rest of the year (except as noted in the “Exceptions”).

THE MAXIMUM BENEFIT

The most we will pay for any one injury or sickness or pregnancy of a covered person during his or her lifetime is \$2,000,000.

- 1. The Maximum Benefit will be fully restored if the covered person gives us proof of his or her good health by our standards. This proof must be approved by us before the Maximum Benefit will be restored. It must be given at the covered person’s expense.
- 2. After the covered person has gone 24 months without any medical care for an injury or sickness, the Maximum Benefit will be fully restored for that injury or sickness.

THE DEDUCTIBLE

The Deductible is the amount of Covered Expenses that a covered person must first incur each year before are paid Major Medical benefits for that year. (We do not pay for these “Deductible” expenses.) They must be incurred while covered under this Coverage.

In most cases, each covered person must meet a yearly Deductible of \$125. It can be satisfied by incurring Covered Expenses for services provided by a PPO Provider, by a Provider who is not a member of the PPO network, or both. We apply expenses to the Deductible in the order they are incurred. If that is not practical, we apply expenses in the order they are claimed.

Covered Expenses incurred on or after October 1 that count toward the Deductible for that year will also count toward the Deductible for the next year.

Family Deductible

The Family Deductible is \$375 per year. This means a family does not have to incur “Deductible” expenses of more than \$375 in any one year. Once 3 or more family members have incurred a combined total of \$375 of

expenses toward their yearly Deductible, each member of that family will be considered to have met his or her Deductible for the rest of the year.

Common Accident Feature

If 2 or more family members are injured in the same accident, no Deductible will apply to Covered Expenses incurred as a result of that accident in the year of the accident nor in the next year. (But expenses not related to the accident are still subject to the Deductible.)

COVERED EXPENSES

To be a Covered Expense, an expense must be:

- reasonable; and
- incurred for the necessary Medical Care of a covered person; and
- incurred only for the Medical Care and to the extent described below.

Any expense we list under Expenses We Do Not Cover is not a Covered Expense.

Hospital Expenses

We cover charges a Hospital makes on its own behalf for:

- Room and Board Services: These include the following services: general nursing care; dietary services; admission services; record keeping services; housekeeping services; and any other regular daily in-patient services the Hospital provides for the type of room the covered person is in.

If any daily charge for a private room exceeds the Hospital's daily charge for its most common semi-private room, the excess is not a Covered Expense.

- Other Services: These are all other services or supplies a Hospital provides. But prescription drugs and prescription medicines are covered here only if they are not covered under the Prescription Drug Coverage.

In the case of a confinement for alcoholism, drug addiction or substance abuse, if the Hospital does not have established facilities for major surgery there is a limit on how much we cover for each day of the confinement. This limit is \$250. It applies to Room and Board Services and Other Services combined.

Other Medical Expenses

We cover charges made for the following:

- Services of a doctor or an anesthetist. But for expenses incurred for doctors' visits while the covered person is an in-patient in a Hospital or similar place, we will only cover up to four visits by all doctors combined in a two day period. Any excess is not a Covered Expense.
- Services of a licensed physiotherapist or licensed occupational therapist.
- Services of a qualified speech therapist to restore speech loss, or correct an impairment, due to (a) a birth defect for which corrective surgery has been performed, or (b) an injury or sickness except a mental, psychoneurotic or personality disorder.
- Care to manually or mechanically detect and correct distortion, misalignment or partial dislocation of the spinal column and related physical therapy or treatment.
- Private duty nursing services provide by a person licensed to provide such service. But there is a limit on how much we cover for these services. This limit is \$125 per day. Any excess expense is not a Covered Expense. And such services provided by a person who is also an employee of or affiliated with the Hospital or similar place in which the covered person is an in-patient will not be a Covered Expense.

- Allergy tests for diagnosing disease.
- Lab tests.

Mastectomy or lymph node dissection, on the same basis as any other surgical procedure. Covered Expenses include:

1. In-patient Care. Are paid benefits for in-patient care for not less than:
 - c. 48 hours after a simple mastectomy or lymph node dissection
 - d. 72 hours after a modified radical mastectomy.

A longer in-patient stay will be covered if it is determined to be necessary. The additional stay must be pre-authorized as required by this Plan. Outpatient surgery or an early discharge will be covered if the attending doctor, in consultation with the covered person, determines that a shorter length of stay is medically appropriate.

2. Reconstructive Surgery. Are paid benefits for Reconstructive surgery following a mastectomy.

For pregnancy on the same basis as an illness, including the following:

1. In-patient Care. Following the delivery of a child, we will pay benefits for Covered Expenses incurred by the mother and her newly born child(ren) in a Hospital or other licensed facility for not less than:
 - a. 48 hours after a vaginal delivery; or
 - b. 96 hours after a cesarean section.

A longer in-patient stay will be covered if it is determined to be necessary. The additional stay must be pre-authorized as required by this Plan.

2. Post-Discharge Care. If the attending doctor, in consultation with the mother, approves a shorter hospital stay, we will pay benefits for at least two Post-discharge visits. Post-discharge will be provided by an appropriately licensed and trained person, and includes, but not limited to the following:
 - a. physical assessment of the mother and the newborn child(ren);
 - b. parent education;
 - c. assistance and training in breast and bottle feeding;
 - d. education and services for complete childhood immunizations; and
 - e. any necessary and appropriate clinical tests, including submission of a metabolic specimen satisfactory to the state laboratory.

Early discharge and post-discharge care must be provided in accordance with nationally recognized guidelines.

- Diagnostic x-ray exams.
- X-ray, radium and radioactive isotope therapy.
- Prescription drugs and prescription medicines, but only if they are not covered under the Prescription Drug Coverage.
- Artificial limbs and eyes, and their repair or (at our option) replacement.
- Casts, splints and surgical dressings.
- Orthopedic appliances (such as trusses, crutches and braces).
- Rental or purchase (at our option) of hospital type bed, wheelchair, iron lung or similar durable medical equipment which is: (a) used solely by the covered person for the treatment of his or her injury or sickness;

and (b) generally not useful to a person who is not injured or sick. But the most we will pay for these expenses during the covered person's lifetime is \$10,000.

- Whole blood or blood plasma, except that which is replaced by or for the covered person.
- Oxygen and the rental of equipment for giving it.
- Anesthesia and fluids needed for surgery.
- Local ambulance services.
- Transportation by rail, ambulance, plane or helicopter from the place where an acute injury or sickness needing specialized attention occurs to the nearest hospital equipped to furnish the needed treatment. That mode of transportation must be medically necessary. If these expenses are more than \$2,500 in connection with any one period of Hospital Confinement, the excess is not a Covered Expense.
- Services provided by an Ambulatory Surgical Center.
- A mammogram screening once a year provided upon the recommendation of a doctor, an advanced registered nurse, or a physicians assistant.
- Services provided by a Birthing Center.
- The following services provided by or through a Federally certified Home Health Care Agency for a covered person in his or her home:
 1. Any service listed as a covered service under this "Other medical Expenses" provision;
 2. Part-time home health aide services, up to 20 hours per week;
 3. Respiratory therapy;
 4. Audiology;
 5. Medical social work;
 6. Nutrition counseling;
 7. Minor equipment, such as commodes and walkers.

We cover these services only if:

- the home health care is according to a written plan established by a doctor; and
- that doctor certifies that confinement in a Hospital or similar place would have been required if home health care were not provided; and
- the covered person is under the continuous care of that doctor during the period of home health care.

Room and board and other services provided by a Convalescent Care Facility for a covered person while an in-patient, up to these limits:

1. A limit per day of 50% of the most common daily semi-private room charge of the Hospital in which the covered person was confined before entering the Facility.
2. A limit of 90 days of convalescent care for any one injury or sickness.

We cover these services only if:

- the covered person was a Hospital in-patient for at least 3 days in a row before entering the facility; and
- benefits were payable under this Coverage for that Hospital stay; and
- the covered person enters the facility within 7 days after leaving the Hospital; and
- the stay results from the same injury or sickness which caused the Hospital confinement; and

- a doctor who cared for the covered person during the Hospital stay recommends, approves and supervises the convalescent care.

A new 3 day Hospital stay must precede a later period of convalescent care if the later care:

- is totally unrelated to the earlier period of care; or
- begins more than 7 days after the earlier care ends; or
- begins after the covered person has resumed his or her normal duties and activities. (For you, this means completing at least one day of active, full-time work.)

The following Hospice Care Services provided by a Hospice or Hospice Team:

1. In-patient Hospice care Services provided under the Hospice Care Program;
2. Out-patient Hospice Care Services provided under the Hospice Care Program; and
3. Bereavement Benefits for counseling services provided after the covered person's death to the members of his or her family. The lifetime maximum benefit applies to all services provided to all members of the family within the 3 month period following the date of the covered person's death.

All periods of Hospice Care in a Hospice Care Program, in-patient and out-patient, are treated as one period of Hospice care unless they are separated by at least 90 days.

We cover these services only if:

- The covered person's doctor:
 - certifies that he or she has a terminal illness and is expected to live 6 months or less. If the covered person lives longer than 6 month, this benefit will be extended if:
 - i) his or her doctor again certifies that the covered person has 6 months or less to live; and
 - ii) the extension is approved by us. An extension of this benefit does not mean that the covered person is entitled to additional benefits. It means that the current benefit will not cease because the covered person lived longer than 6 months; and
 - recommends admission to a Hospice Care Program.

The Hospice care Program is provided:

- at home by a Hospice Team, under a program which is available 24 hours a day, 7 days a week; or
- as an in-patient in a Hospice.
- The Hospice Care Services are ordered by the doctor who is directing the Hospice Care Program.

The charges are made by the Hospice or charged for under the Hospice Care Program.

The Hospice Care Services are provided within 6 months from the date the person entered or re-entered (after a period of remission) the Hospice Care Program. A "period of remission" means a period during which:

- the progression of a terminal illness stops; or
- there is real improvement in the condition of the person.

We do not pay for services or supplies provided during a Period of Remission. This does not apply if the person is not discharged from the Hospice Care Program

EXPENSES WE DO NOT COVER

We do not cover expenses for the following Medical Care, and none of these expenses will figure in any calculation of benefits. We do not cover expenses:

1. For Medical Care not recommended and approved by a doctor.
2. For Medical Care received in a facility owned or run by or furnished at the expense of the U.S. Government or one of its agencies. But this does not apply to Covered Expenses furnished by a Veterans Administration hospital for non-service connected disabilities.
3. For Medical Care for which the covered person-without this coverage-would not be legally obligated to pay.
4. For Medical Care for cosmetic purposes.

But we do cover:

- Cosmetic treatment of an injury for up to 24 months after the accident, if the treatment starts within 90 days after the accident
 - Reconstructive surgery which is incidental to or follows an injury or a sickness. But we will not cover such surgery if it is performed mainly to improve the mental or emotional state of the covered person.
 - Reconstructive surgery because of a congenital disease or birth defect of a covered dependent child which impairs a function of the body.
5. For dental care or treatment.

But we do cover:

- Hospital services for in-patient care received while confined for dental care or treatment.
 - Dental care or treatment of an injury to the jaw or sound natural teeth for up to 24 months after the accident, if the treatment starts within 90 days after the accident.
6. For eye refractions, surgical correction of a refractive disorder of the eye, eyeglasses, contact lenses, hearing aids, or their fittings.
But we do cover the first pair of eyeglasses or contact lenses which the doctor prescribes after cataract surgery.
 7. For an injury or a sickness due to war or armed conflict which involves one or more countries.
 8. For an injury or a sickness which arises out of or in the course of the covered person's employment or for which he or she is covered by Workers' Compensation or a similar law. But this does not apply to covered person's who are not eligible for coverage under such a law.
 9. For services furnished by one of these persons: (a) a person who normally lives with the covered person; (b) you or your spouse; or (c) you or your spouse's parent, child, brother or sister.
 10. For Medical Care received while outside the United States and Canada. But we do cover Medical Care received during the first 60 days of such an absence.
 11. For custodial care or care to help in the routine of daily living.
 12. For routine nursery and pediatric care of a newborn child. But we do cover these services for routine care received before the child leaves the Hospital in which he or she was born: (a) Hospital nursery services; (b) routine tests and doctors' examinations; and (c) circumcision.
 13. For routine health examinations, physical check-ups or preventive care, except for those services specifically included elsewhere in this section.

14. For Treatment of: (a) Weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions; or (b) Corns, calluses or toenails.

But we do cover: (i) and open cutting operation for any condition listed in (a) above; (ii) the removal of nail roots; and (iii) treatment of a condition listed (b) above, if the covered person has a metabolic or peripheral vascular disease. We will pay up to \$21,000 of benefits in a calendar year for all treatment in (i), (ii) or (iii) above, or more than one of these.

15. For a Pre-Existing Condition. This is: (i) an injury or a sickness or a related sickness or injury of pregnancy for which the covered person consulted with a doctor, took medicine, or received other Medical Care or advice within 12 months before becoming covered; or (ii) the existence of symptoms which would cause an ordinary prudent person to seek medical advice, diagnosis, care or treatment within 12 months before becoming covered.

We will cover expenses incurred for such a condition without this limit after a person has been covered under this Coverage for 6 months in a row.

But if you became covered under this Coverage after April 1, 1997, we will pay up to \$1,000 for such a condition before we apply this Exclusion.

This provision will not apply to any person who became covered under this Coverage on its effective date, and who was covered under the Company's Old Plan on the date it terminated. "Old Plan" means your Company's prior plan of medical expense coverage which was replaced by this plan.

This provision will not apply to an adopted child, or child placed for adoption, if the child becomes covered when he or she is first eligible under this plan.

16. For care to manually or mechanically detect and correct distortion, misalignment or partial dislocation of the spinal column and related physical therapy or treatment.

But we do pay up to \$500 of benefits in a calendar year for such care before we apply this Exclusion.

17. For Medical Care for sex transformations.

18. For surgery to correct malocclusion of the jaw due to skeletal deformity.

19. For Medical care for artificial insemination, for in-vitro fertilization, for treatment of infertility or to reverse surgical sterilizations.

20. For Medical Care provided by you or your covered dependent's Company, labor union, or similar group.

21. For Medical Care of an injury due to taking part in a felony.

WHEN WE EXTEND BENEFITS

If the covered person is confined as an in-patient in a Hospital on the day his or her coverage ends, these Major Medical benefits will be available for Covered Expenses just as if coverage had not ended. This extension of benefits will end on the first of these dates.

- 3 months from the date coverage ended; or
- the date the covered person is no longer confined in the Hospital; or
- the date the maximum benefits for hospital expenses under the Plan have been paid.

ADDITIONAL MAJOR MEDICAL BENEFITS

The benefits in this Section are part of your Major Medical Coverage. We list them here because we figure them differently. But all of the other terms of the **Major Medical Coverage** Section apply here too.

SECOND SURGICAL CONSULTATION BENEFIT

Under this Benefit, are paid for Covered Expenses for the fees of Surgical Specialists for consultations about the need for non-emergency surgery.

- it must take place within 90 days after a doctor first recommends the surgery; and
- it must take place before the covered person enters the Hospital for the surgery; and
- the recommended procedure must be one which is normally done only on a Hospital in-patient basis; and
- the Specialist must examine the covered person in person

Are paid 100% of the Covered Expenses incurred for the consultation and any diagnostic x-ray or lab exams done in connection with that consultation as follows, before we apply the deductible:

- up to \$100 per consultation; and
- then are paid for the rest of these expenses as explained in the **Major Medical Coverage** Section; and
- for up to two consultations for any one recommended procedure. (But each must be with a different Surgical Specialist.)

A Surgical Specialist is a Doctor who holds, in the surgical specialty for which surgery is recommended, the rank of: Diplomat of an American Board (M.D.); or Certified Specialist (D.O.).

Expenses not covered under the **Major Medical Coverage** Section are not covered here. Also, under this Benefit we do not pay:

1. For drugs or dressings.
2. If the Specialist who is consulted does the surgery.

VISION CARE (ROUTINE)

An allowance of \$150 per year applies to the following benefits:

- Routine eye examinations, including refractions.
- Prescription eyeglass lenses and frames, or contact lenses, including expenses associated with their fitting.

DENTAL COVERAGE

Refer to the **General Information About Your Health Care Coverages** Section to see how certain terms used in this Section are defined.

WHAT IS DENTAL COVERAGE?

Under this Coverage, are paid the benefits shown below if a covered person incurs Covered Dental Expenses. These expenses must be incurred while he or she is covered under this Coverage.

“Covered Dental Expenses” include many kinds of expenses you and your family have in connection with dental care. We describe them later on in this Section. But expenses for orthodontic treatment are not considered Covered Dental Expenses under this Coverage. The benefits for this type of treatment are described in the **Orthodontic Coverage** Section.

Some base rules apply to the Coverage. It is important to understand them:

1. All services must be performed by or under the direction of a dentist. A dentist is a person licensed to practice dentistry or perform oral surgery.
2. Before any treatment (other than emergency treatment) starts that will cost more than \$500, we must receive the following items.

- a plan of the proposed treatment; and
 - the x-rays; and
 - a list of the charges for that treatment
3. When more than one method of treatment is available, we will cover only the least expensive method.
 4. We cover only the services listed in the Table of Dental Services in the next Section.

We describe these services as Preventive Services, Basic Services, or Major Services. Preventive Services include cleaning and x-rays. Basic Services include oral surgery, periodontics (care of gums), endodontics (root canal therapy) and fillings. Major Services include inlays and crowns (where fillings cannot be used), bridges and dentures.

THE BENEFITS

Preventative Services

Are paid 80% of the Covered Dental Expenses the insured incurs for Preventive Services, up to the Maximum Benefit Per Year for all Covered Dental Expenses.

Basic Services

After the yearly Deductible for dental services is met, are paid 80% of the Covered Dental Expenses the insured incurs for Basic Services during the rest of the year, up to the Maximum Benefit Per Year for all Covered Dental Expenses.

Major Services

After the yearly Deductible for dental services is met, are paid 50% of the Covered Dental Expenses the insured incurs for Major Services during the rest of the year, up to the Maximum Benefit Per Year for all Covered Dental Expenses during the rest of the year.

MAXIMUM BENEFIT PER YEAR

The most we will pay for all Covered Dental Expenses incurred by a covered person in any one year is \$1,000.

But if the person's coverage starts more than 31 days after his or her eligibility date, the most we will pay for all Covered Dental Expenses incurred during his or her first Benefit Year is \$150. (A covered person's first Benefit Year is the 12 month period which starts on the date his or her coverage under this Coverage starts.)

THE DEDUCTIBLE

The Deductible is the amount of Covered Dental Expenses that a covered person must first incur before we start to pay benefits. We do not pay for these expenses under this Coverage. These expenses must be incurred while covered under this Coverage.

The Deductible is \$50 and must be met each year. It applies to both Basic Services and Major Services. But it does not apply to Preventive Services. We apply expenses to the Deductible in the order they are incurred. If both expenses for Basic Services and Major Services are incurred during the same course of treatment, we will apply the expenses from the Basic Services to the Deductible first, and then apply the expenses for Major Services, no matter which came first.

Any person who was covered under our Old Plan on the day it ended and who is covered under this Coverage on its effective date, we will apply certain expenses incurred under the Old Plan toward meeting the deductible of this Coverage. We will do this if:

- those expenses were applied to the deductible of the Old Plan; and

- were incurred in the year in which this Coverage took effect; and
- Are covered Expenses under this Coverage; and
- are subject to a similar deductible requirement under this Coverage.

“Old Plan” means our prior plan or group coverage which provides benefits similar to the benefits provided by this Coverage.

Family Deductible Limit

There is a maximum of 2 Deductibles per family per year. This means that once 2 covered family members have each met their Deductible for a year, every other member of that family will be considered to have met his or her Deductible for the rest of that year.

Covered Dental Expenses

To be a Covered Dental Expense, an expense must be:

- reasonable and necessary; and
- incurred for a service listed in the Table of Dental Services.

Any expense we list under **Expenses We Do Not Cover** is not a Covered Dental Expense.

EXPENSES WE DO NOT COVER

We do not cover expenses for the following, and none of these expenses will figure in any calculation of benefits. We do not cover any service.

1. Received in a facility owned or run by or furnished at the expense of the U.S. Government or one of its agencies. But this does not apply to Covered Expenses furnished by a Veterans Administration hospital for non-service connected disabilities.
2. For which the covered person-without this coverage-would not be legally obligated to pay.
3. For an injury or a sickness which arises out of or in the course of the covered person’s employment or for which he or she is covered by Workers’ Compensation or a similar law. But this does not apply to covered person who are not eligible for coverage under such law.
4. Rendered mainly for cosmetic purposes, or to correct congenital defects.
5. To the extent benefits are payable for that service under any other Coverage of this Plan.
6. To replace lost or stolen appliances.
7. To replace any prosthetic appliance, crown or bridge within 5 years of its last placement.
8. Which began before the person was covered under this Coverage.
9. To increase vertical dimension or restore occlusion.
10. Rendered as an orthodontic services.
11. Which is not listed in the Table of Dental Services.
12. For services furnished by one of these person: (a) a person who normally lives with the covered person; (b) you or your spouse; or (c) you or your spouse’s parent, child, brother or sister.
13. For an initial placement of a denture or a fixed bridge which involves the replacement of one or more natural teeth which were missing before the person became covered under this Coverage.

But we do cover such a denture or bridge if it also replaces a natural tooth which is extracted while covered.

TABLE OF DENTAL SERVICES

PREVENTATIVE SERVICES

Routine oral examinations (not more than once every 6 months):

Initial examination

Periodontic examination

Entire denture series, at least 14 films, including bitewings if necessary (not more than once every 3 years).

Intraoral - Single film.

Intraoral - Each additional film (not more than 12).

Intraoral - Occlusal view, maxillary or mandibular, each.

Extraoral - Superior or inferior maxillary, one film.

Each additional film.

Bitewings (not more than once every 6 months)

Single film.

Two films

Three films.

Four films.

Panographic survey (considered entire denture series).

Prophylaxis (not more than once every 6 months)

Adult - including scaling and polishing.

Child

Topical application of sodium fluoride (including prophylaxis)

- payment limited to once each year to age 19.

Topical application of stannous fluoride (including prophylaxis)

- payment limited to once each year to age 19.

Topical application of sealants – permanent molars only (applied to children ages 6 to 19 – not more than once a lifetime):

Per quadrant

Per tooth

Space Maintainers (For Children Under Age 19)

Fixed – unilateral type (band type).

Removable – bilateral type.

Study models for Space Maintainers.

BASIC SERVICE

Restorative Dentistry

(See Major Services for other restorative procedures)

Amalgam Restorations:

Primary teeth – cavities involving:

One tooth surface.

Two tooth surface.

Three tooth surface (or more).

Permanent teeth – cavities involving:

One tooth surface.

Two tooth surfaces.

Three tooth surfaces (or more).

Silicate, plastic, composite restorations:

Silicate cement filling.

Plastic filling.

Composite filling.

Stainless steel crowns – primary or permanent (For children under age 19).

Endodontics

Pulp Capping.

Remineralization (CaOH, temporary restoration) per tooth as a separate procedure only.

Therapeutic pulpotomy (in addition to restoration, per treatment).

Vital pulpotomy.

Root Canal (including necessary x-rays and cultures, but excluding Final restoration):

Single rooted tooth canal therapy (anterior).

Bi-rooted tooth canal therapy (bicuspic).

Tri-rooted tooth canal therapy (molar).

Apicoectomy:

Separate procedure.

Including root canal therapy.

Periodontics

Gingivectomy, per quadrant.

Gingivectomy, treatment per tooth (fewer than 6 teeth).

Scaling and root planing.

Subgingival curettage, root planing (per quadrant).

Gingivectomy, mucogingival surgery, per quadrant.

Gingivectomy, osseous surgery, per quadrant.

Free soft tissue grafts.

Correction of occlusion related to periodontal problems.

DENTURE REPAIRS – COMPLETE OR PARTIAL

(See Major Services for other denture repairs)

Repair broken denture – no teeth damaged.

Repair broken denture – replace one broken tooth.

- replace additional teeth, each.

Replace broken tooth on denture – no other repairs

ORAL SURGERY

Extractions:

Uncomplicated (including routine post-operative visits):

Single tooth.

Each additional tooth.

Surgical removal of erupted tooth.

Impacted teeth:

Removal of tooth (soft tissue).

Removal of tooth (partially bony).

Removal of tooth (completely bony).

Other surgical procedures:

Closure of oral fistula of maxillary sinus.

Transplantation of tooth or tooth bud.

Crown exposure for orthodontia.

Biopsy of oral tissue (hard).

Biopsy of oral tissue (soft).

Alveolar or Gingival reconstruction:

Alveolectomy (in addition to removal of teeth), per quadrant.

Alveolectomy (edentulous), per quadrant.

Alveoplasty with ridge extension, per arch.

Excision of periocoronary gingival.

Excision of tumors:

Benign tumor, small (less than 1.25 cm).

Benign tumor, large (1.25 cm or larger).

Malignant tumor – up to 1.25 cm.

Malignant tumor – over 1.25 cm.

Excision of cysts:

Odontogenic cyst – up to 1.25 cm.

Odontogenic cyst – over 1.25 cm in diameter.

Nonodontogenic cyst – up to 1.25 cm in diameter.

Nonodontogenic cyst – over 1.25 cm in diameter.

Excision of bone tissue:

Removal of exostosis – maxilla or mandible.

Removal of palatal torus.

Radical resection of bone for tumor with bone graft.

Surgical Incision:

Intra-oral incision and drainage of abscess.

Extra-oral incision and drainage of abscess.

Incision and removal of foreign body from soft tissue.

Removal of foreign body from bone (independent procedure).

Sequestrectomy for osteomyelitis or bone abscess, superficial.
Maxillary sinusotomy for removal of tooth fragment or foreign body.

Other Oral Surgery:

Arthrocentesis.
Suture of soft tissue wound or injury, small.
Suture of soft tissue wound or injury, complicated.
Injection of trigeminal nerve branches.
Frenectomy.
Excision of hyperplastic tissue, per arch.
Sialolithotomy – removal of salivary calculus.
Dilation of salivary duct.

OTHER VISITS, EXAMINATIONS, AND ADJUNCTIVE GENERAL SERVICES

Inhibiting appliance to correct thumb sucking:

Removable.
Fixed or cemented.
Emergency palliative treatment of dental pain.

Anesthesia, general:

Office procedure.
Hospital procedure.
Special Consultation – by specialist for case presentation when diagnostic procedures have been performed by general dentist.

Office visits – provided no other services performed:

During regularly scheduled office hours.
After regularly scheduled office hours.
Post-operative visit (sutures and complications) after multiple extractions and impaction.
(A Covered Dental expense only when teeth cannot be restored with a filling material. See Basic Services for other restorative procedures.)

Inlays:

One tooth surface.
Two tooth surfaces.
Three or more tooth surfaces.
Onlays per tooth, extra.
Crowns (Single Restoration):
Acrylic.
Acrylic with gold.
Acrylic with metal
Porcelain.
Porcelain with gold.
Porcelain with metal.
Gold (Full).

Metal (Full).

$\frac{3}{4}$ Gold.

Steel post and composite or amalgam in addition to crown.

Recementation:

Inlay.

Crown.

Prostodontics:

Complete maxillary denture.

Complete mandibular denture.

Partial dentures:

Upper or lower, without clasps, acrylic base.

Upper or low, with 2 clasps, acrylic base.

Upper or lower, with bar and 2 clasps, acrylic or cast base.

Removable bridge, unilateral, one piece casting.

Upper or lower, full cast with 2 clasps.

Each additional clasp with rest.

Denture Repairs (See Basic Services for other denture repairs):

Add tooth to partial denture to replace extracted tooth:

Each tooth, not involving clasp or abutment tooth.

Each tooth, involving clasp or abutment tooth.

Replace damaged clasp on denture.

Replace broken clasp with new clasp or denture.

Each additional clasp with rest.

Denture rebasing, upper or lower, complete or partial (not more than once every 3 years).

Denture relining (not more than once each year):

Upper or lower, complete or partial – office

Upper or lower, complete or partial – laboratory

Temporary denture, partial-stayplate-upper or lower.

Special tissue conditioning, per denture (limited to two treatments per arch and not more than once each year).

Pontics:

Cast gold (sanitary).

Cast metal (sanitary).

Steele's facing.

Tru-Pontic type.

Porcelain baked to gold.

Porcelain baked to metal.

Plastic processed to gold.

Plastic processed to metal.

Repair or replace broken pontic.

Crowns – Abutments:

Acrylic.

Acrylic with gold.

Acrylic with metal.

Porcelain.

Porcelain with gold.

Porcelain with metal.

Gold (3/4 Cast).

Gold (Full Cast).

Recent bridge.

Simple stress breakers.

(Dentures, partial dentures and relines procedures include adjustments for 6 month period following installation. Charges for specialized techniques and characterizations are not Covered Dental Expenses.)

ORTHODONTIC COVERAGE

Refer to the **General Information About Your Health Care Coverages** Section to see how certain terms used in this Section are defined.

WHAT IS ORTHODONTIC COVERAGE?

Under this Coverage, are paid the benefits shown below if a covered person incurs Covered Orthodontic Expenses. These expenses must be incurred while he or she is covered under this Coverage. The orthodontic treatment must start after the person has been covered under this Coverage for at least 180 days in a row. This 180 day period does not apply to the person who was covered under our prior Orthodontic plan on the day it ended and who is covered under this Coverage on its effective date.

Some basic rules apply to your orthodontic coverage. It is important to understand them:

1. All services must be performed by a dentist. A dentist is a person licensed to practice dentistry or perform dental surgery.
2. Before any treatment starts, we must receive the following items:
 - the class and description of the malocclusion; and
 - the charge for the entire course of treatment; and
 - the estimated time needed to complete that treatment.

We may also require that the pre-treatment study models be sent to us.

THE BENEFITS

50% of the total amount of Covered Orthodontic Expenses the covered person incurs for the entire course of treatment. But the most we will pay for a covered person under this Coverage during his or her lifetime is \$500.

These benefits are paid in quarterly installments. The number of quarterly payments we make is based on the length of time the dentist estimates it will take to complete the course of treatment. But 2 years is the maximum period of time we will use to determine the number of quarterly payments.

The first installment is due on the date the orthodontic appliances are first put in. The second installment is due 3 months later, and so on, until all installments have been paid.

We will not make a payment unless, on the date it is due, the covered person is:

- still covered under this Coverage; and
- still receiving orthodontic treatment.

COVERED ORTHODONTIC EXPENSES

To be a Covered Orthodontic Expense, an expense must be:

- reasonable and necessary;
- incurred for the diagnosis and treatment of malposed teeth which starts after the person has been covered under this Coverage for at least 180 days in a row. This 180 period does not apply to a person who was covered under our prior Orthodontic plan on the day it ended and who is covered under this Coverage on its effective date.

Any expense we list under **Expenses We Do Not Cover** is not a Covered Orthodontic Expense.

EXPENSES WE DO NOT COVER

We do not cover expenses for the following, and none of these expenses will figure in any calculation of benefits. We do not cover any service or treatment:

1. Received in a facility owned or run by or furnished at the expense of the U.S. Government or one of its agencies. But this does not apply to Covered Expenses furnished by a Veterans Administration Hospital for non-service connected disabilities.
2. For which the covered person-without this coverage-would not be legally obligated to pay.
3. For which benefits are payable under any other Coverage of this Plan.
4. Which began before the person had been covered under this Coverage for at least 180 days in a row. This 180 day period does not apply to the person who was covered under our prior Orthodontic plan on the day it ended and who is covered under this Coverage on its effective date.

If the person's coverage starts more than 31 days after his or her eligibility date, we will not cover any service or treatment started before the person has been covered under this Coverage for at least 365 days in a row.

5. For services furnished by one of these persons: (a) a person who normally lives with the covered person; (b) you or your spouse; or (c) you or your spouse's parent, child, brother or sister.

COORDINATION OF HEALTH CARE BENEFITS

WHEN WE COORDINATE WITH OTHER PLANS.

You or your covered dependents may also have health care coverage under another Plan. If so, we coordinate what is paid under this Plan with the benefits from these other Plans. As a result, we may reduce what is paid under this Plan so that a covered person never receives a total, from all Plans, of more than 100% of allowable expenses incurred during a year.

Here are some basic terms that you should know.

Health Care includes dental care as well as medical care.

An **allowable expense** is any necessary, reasonable and customary item of expense covered in full or in part under a Plan. (When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service will be treated as both an allowable expense and a benefit paid.)

A **Plan** includes any health care insurance, benefits or services provided through one or more of the following:

- group, blanket or franchise insurance;

- group service plans or other group prepayment coverage;
- any other program of benefits or services for individuals as a group, whether insured or not;
- individual or group motor vehicle no-fault insurance; or
- any government program or coverage required or provided by law, except Medicare and Medicaid. (See the end of this Section for details on how we coordinate with Medicare coverage.)

This Plan includes all the Coverages under the Plan that provides health care expense benefits.

HOW WE COORDINATE AMONG PLANS

To coordinate among Plans, we must determine the order in which the various Plans will pay benefits.

Another Plan will not affect our paying benefits if our rules call for us to determine benefits first. But if the benefits of the other Plan are to be paid before those of this Plan, the benefits of this Plan will be reduced as described above.

These are our rules to determine the order of paying benefits:

1. A Plan which does not have a coordination of benefits provision before a Plan which has one.
2. A Plan which covers a person other than as a dependent pays before a Plan which covers him or her as a dependent.
3. A Plan which covers a child as the dependent of a person whose month and day of birth occurs earlier in the year pays before a Plan which covers the child as the dependent of a person whose month and day of birth occurs later in the same year. If both parents have the same birthday, the Plan which has covered the parent longer pays before the Plan which has covered the other parent for a shorter period of time. But, if the other plan does not have this rule, a Plan which covers a child as a dependent of the father pays its benefits before a Plan which covers the child as a dependent of the mother.

But in the case of a dependent child whose parents are separated or divorced:

- Sometimes there is a court decree which sets financial responsibility for the child's health care expenses. If this is the case, a Plan which covers the child as a dependent of the parent with that responsibility pays before any other Plan which covers the child as a dependent.
 - If the parent with custody of the child has not remarried, a Plan which covers the child as a dependent of that parent pays before a Plan which covers the child as a dependent of the other parent.
 - If the parent with custody of the child has remarried, a Plan which covers the child as a dependent of that parent pays before a Plan which covers the child as a dependent of the stepparent. And a Plan which covers the child as a dependent of the stepparent pays before a Plan which covers the child as a dependent of the parent without custody.
 - If a court decree states that the parents share joint custody, without stating that one of the parents is responsible for the child's health care expenses, the plans covering the child shall determine the order of the benefits as if the child's parents are not separated or divorced.
4. A Plan which covers a person as an active employee, or as the dependent of such an employee, pays before a Plan which covers that same person as a retired employee, or as the dependent of such an employee.
 5. If the above rules do not set an order of payment, then the Plan which has covered the person longer pays first.

To administer this provision, we have the right to:

- recover any sum we paid the other Plan should have paid; and
- repay any part for a payment made by that party, when the payment should have been made by us; and

- give or get information we need to coordinate among Plans. (You are required to provide us with any information we need to pay the claim.)

HOW WE COORDINATE WITH MEDICARE

This provision applies only when Medicare pays its benefits before the Plan. When Medicare is required by federal law to pay after this Plan, this provision will not apply.

When a person is eligible for Medicare, we figure benefits under this Plan as follows:

1. First, we calculate benefits just as if the person were not eligible for Medicare. (If the person has not enrolled for all parts of Medicare, we reduce his or her health care expenses by the amount that Medicare would have paid if he or she had enrolled).
2. Next, we take the total amount charged, subtract what Medicare paid, subtract any provider write off then pay the lesser of the balance owed or the amount calculated in No. 1 above. We may reduce what we pay under this Plan so that a covered person never receives a total, from all Plans, of more than 100% of allowable expenses incurred during a year.

There is one exception to No. 2 above. If a person stays in a private room in a Hospital, we apply the Medicare benefits against the Plan's daily limit for a private room rather than against the Hospital's actual charges for that room. This means that the difference between this Plan's private room limit and what the Hospital charges for that room is not paid for by this Plan.

WHEN YOUR COVERAGE ENDS

Coverage under the Plan will end on the first of these dates:

- the last day of the month that falls on or next after the date your employment ends. (This is the date you stop active, full-time work. Under certain circumstances your coverage may continue. Check with your Benefits Administrator to see what the Plan provides.)
- the date the Plan (or that Coverage under the Plan) terminates.
- the date the Plan is changed to end coverage for your class.
- the last day of the month that falls on or next after the date you are no longer in an eligible class for that Coverage.
- The last day of the period for which you have paid, when due, the required coverage charges on your behalf.
- In the case of your coverage under the Hospice Care and Major Medical Coverages, the date you elect Medicare as your primary coverage. This applies when federal law requires Medicare to pay its benefits after this Plan but allows you to choose Medicare as your primary coverage.

See the next Section for details on how you may obtain an individual policy when group coverage ends.

WHEN YOUR DEPENDENTS COVERAGE ENDS

Coverage under the Plan for a dependent will end on the first of these dates.

- the last day of the month that falls on or next after the date your dependent is no longer an eligible dependent.
- the date your coverage ends.
- the date the Plan (or that Coverage under the Plan) terminates.
- the date the Plan is changed to end coverage for your dependent's class.

- the last day of the month that falls on or next after the date your dependent is no longer in an eligible class for that Coverage.
- The last day of the period for which you have paid, when due, the required coverage charges on your dependent's behalf.
- In the case of your spouse's coverage under the Hospice Care and Major Medical Coverages, the date he or she elects Medicare as his or her primary coverage. This applies when federal law requires Medicare to pay its benefits after this Plan but allows the covered person to choose Medicare as his or her primary coverage.

See the next Section for details on how your dependent may obtain an individual policy when group coverage ends.

SPECIAL CONTINUATION OF COVERAGE

FOR A HANDICAPPED CHILD

Your child's health care coverage will not end just because the child has reached the age limit shown in Section 2, if he or she:

- is not able to earn his or her own living as a result of physical handicap or mental retardation; and
- became handicapped before reaching that age limit; and
- mainly depends on you for support.

Within 31 days after your child reaches the age limit, you must send us proof of his or her dependency and handicap.

We may ask for more proof of the child's dependency and handicap. But after the child's coverage has been continued under this provision for at least 2 years, we will not ask for proof more than once each year.

This continued coverage will end on the first of these dates:

- the date the child is no longer handicapped or dependent on you;
- the date the child's coverage would end for any reason listed under **When Your Dependents Coverage Ends** – other than reaching the age limit. (For example, the date your coverage ends.)

IF THERE IS A STRIKE, LOCKOUT, OR OTHER LABOR DISPUTE

The sources of contributions to the plan: You may be required to contribute to the cost of the plan coverages for yourself and for your dependents.

Under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), you may be eligible for a special extension of group coverage when you are no longer eligible under this plan. If you elect a COBRA continuation of coverage, you will not be entitled to the Disability Extension explained below.

EXTENSION OF GROUP COVERAGE – COBRA

You may continue your group coverage past the point it would normally terminate as follows:

- Up to 18 months for you and your covered dependents from the date your employment terminates (except for gross misconduct), or the date you lose eligibility due to a reduction in hours. This includes but is not limited to a leave of absence or a labor dispute. However, coverage will be extended for up to 29 months for you or your covered dependent who is disabled according to the Social Security Act at the time of the initial COBRA qualifying event. Special notification requirements apply.
- Up to 36 months for your covered dependents from the date of the employee's death, divorce or legal separation, or the date a dependent child ceases to meet the eligibility requirements of this plan.

- If you are entitled to Medicare, you are not eligible for the COBRA provisions. If you are an active employee and elect Medicare as primary, your covered dependents may stay on the plan. When you cease to be an active employee, your covered dependents may apply for a COBRA extension. If a COBRA-covered employee becomes entitled to Medicare after COBRA coverage begins, the spouse or dependent child who is covered under the plan's COBRA extension may continue the COBRA extension for an additional 36 months from the date the employee became entitled to Medicare.
- If you are covered under another group health care plan when initially eligible for the COBRA extension, or if you become covered under another group health plan after your COBRA continuation begins, you will not be eligible for COBRA continuation unless the other plan limits or excludes coverage for a preexisting condition you have. In such a case, you will not be eligible for COBRA continuation once that preexisting condition is covered.
- If timely notice of the qualifying event and your COBRA election rights are given as provided by COBRA, you will have 60 days from the date of the COBRA election notice or from the date coverage would terminate during which you may elect COBRA continuation coverage under this plan. Your group must notify the Company of your election will constitute a waiver of your rights to COBRA continuation coverage under this plan. Failure to provide timely notices may not, in all cases, terminate your right to continuation coverage; however, such failure will eliminate any obligation of the Company to provide continuation coverage under this plan.

This continuation of coverage provision will be subject to the COBRA law and regulations. If there is any conflict between these provisions and COBRA, the minimum requirements of COBRA will govern.

If you elect a COBRA continuation of coverage, you will no longer be entitled to any other extension of coverage that may be available under your plan as explained in this brochure.

You or your dependents may be responsible for payment of the Company rates during an extension of coverage. Payment must continue to be submitted through your Company Representative. The right to an extension of coverage will end when your Company's coverage with the Fund terminates.

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

Eligibility:

Ryan VanAckeren - 1.800.562.5226

Bambi Harrison - 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



A handwritten signature in black ink, appearing to read "Richard Rodruck", is written over a solid horizontal line.