GROUP BENEFITS PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

FOR

STAR TRANSPORTATION, INC.
BRONZE EMPLOYEE BENEFIT PLAN

EFFECTIVE 11/01/1993

RESTATED 02/01/08

Dear Plan Participant:

This booklet has been prepared to explain the health care coverage available to you through the Star Transportation, Inc. Employee Benefit Plan. We recommend that you read the booklet and become familiar with the various types of coverages and benefits to which you and your dependents may be entitled should the need arise.

The day-to-day administration of the Plan has been delegated to a professional administrator, North America Administrators, L.P. Should you have any questions regarding the Plan, its operation and benefits, as well as any claim decisions or payments, please do not hesitate to contact your personnel office or the administrator either by mail at:

1212 8th Avenue South
P.O. Box 1984
Nashville, TN 37202

or by telephone at: (615) 256-3561.

The administrative staff will be available during normal working hours to assist you in any way possible.

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I. SCHEDULE OF BENEFITS

A. LIFE INSURANCE

1. Basic Life Insurance Benefit..Per Scheduled Amount
2. Accidental Death & Dismemberment Benefit.............................Per Scheduled Amount

B. COMPREHENSIVE MEDICAL BENEFITS

Lifetime Maximum Benefits:

All Conditions - Other internal limits may apply $25,000.00
Transplant...$25,000.00
Premature Baby $25,000.00
TMJ/Jaw Care $1,000.00

Annual Maximum Benefits –
All Conditions – Other internal limits may apply:

First year of participant coverage $5,000.00
Second year of participant coverage $10,000.00
Third year of participant coverage $25,000.00
Subsequent years of participant coverage $25,000.00

Other Annual Maximum Benefits:

All Conditions - Other internal limits may apply $25,000.00
Chiropractic Care..20 visits
Chiropractic X-ray $250.00
Home Health Care ....100 visits
Podiatry...$500.00
Prescription Benefit $2,000.00

	PPO Benefits	NON-PPO Benefits
Deductible:		
Individual	$ 750	$1,500
Family Deductible	$1,500	$3,000
Out-of-Pocket Maximum (Not including deductible):		
Per Individual	$2,500.00	$25,000.00
Per Family	$5,000.00	$50,000.00

After the Individual (or Family) Out-of-Pocket Maximum has been reached for the calendar year, the Plan will pay 100% of subsequent covered expenses incurred by the individual (or family) during the remainder of that calendar year. Except when there is other secondary coverage for the same illness or injury, the Plan will continue to pay at the applicable 70%, or 50% co-insurance percentage.

Benefits will be paid at the PPO level for Covered Expenses incurred for radiology, anesthesiology, pathology, and laboratory, provided services are performed in a PPO Network facility or when services are upon referral by a PPO Physician.

If services are not offered by a Preferred Provider or if a Covered Person is traveling outside of the geographical area (more than 50 miles) of the Preferred Provider Organization, benefits will be paid as if the provider was in the Preferred Provider Organization.

	PPO **Benefits**	NON-PPO **Benefits**
	Subject to Deductible:	Subject to Deductible:
Inpatient		
Room, Board & Ancillaries	70%	50%
Surgery (Physician Charges)	70%	50%
Physician Visits in Hospital	70%	50%
Skilled Nursing Facility	70%	50%
Outpatient		
Diagnostic X-Ray & Lab* -refer to Lab One Benefit	70%	50%
Surgery-Short Stay Unit or Outpatient Department	70%	50%
Home Health Care/Hospice	70%	50%
All other eligible charges	70%	50%
Chiropractic Care - 20 visits per year	70% up to $30 per visit	50% up to $30 per visit
	Not Subject to Deductible:	Subject to Deductible:
Physician Office	100% after $25 per visit co-payment up to a maximum payment of $100.00 balance at 70%	50%
Allergy Injections	70%	50%
	Not Subject to Deductible:	Not Subject to Deductible:
Emergency Room Charges	70% $250.00 Co-payment per visit.	50% $250.00 Co-payment per visit.
Preventive Care - includes physical exam, mammogram, and pap smear	$25 co-pay, then 100% up to maximum payable of $750 per calendar year	not covered
Well Child Care - ages 0 – 6 years	$25 co-pay, then 100% up to maximum payable of $350 per calendar year	not covered

C. PRESCRIPTION DRUG CARD BENEFIT

Pharmacy Co-pay (30 day supply maximum)

Generic	$15.00 or 20%, whichever is greater
Formulary Brand	$35.00 or 30%, whichever is greater
Non-Formulary Brand	$50.00 or 35%, whichever is greater

Mail Order Co-pay (90 day supply maximum)

Generic	$35.00 or 20%, whichever is greater
Formulary Brand	$65.00 or 30%, whichever is greater
Non-Formulary Brand	$95.00 or 35%, whichever is greater

D. DENTAL BENEFITS- If Eligible

Calendar year deductible – Class B & C only.

Per individual	$50.00
Per family	$150.00

Calendar year deductible – Class D only.

Per individual	$100.00

% Payable

Class A – Preventive	100%
Class B – Basic	80%
Class C – Major	70%
Class D – Orthodontia	50%

Maximum Benefits Payable:

Annual Maximum Benefit (Class A, B, and C combined)	$1,250.00
Lifetime Maximum Benefit (Class D)	$1,000.00

E. VISION BENEFITS

% Payable	50%
Maximum Annual Benefit	$225.00

F. LAB CARD BENEFIT

Outpatient laboratory charges billed by LabCard	100%

Outpatient laboratory services billed by LabCard are payable at 100%. In order for employees to have their lab work performed at no cost to them, their lab work must be sent to LabCard for testing. The employee must inform their physician's office that their lab specimens are to be sent to LabCard to ensure that their specimens are not mistakenly sent to another reference laboratory. Employees should show their Healthcare I.D. Card at their physician's office when they check in, and let the office personnel know that they intend to use LabCard for their lab work. Employees should also remind whoever is collecting their specimens that their specimens need to be sent to LabCard for testing. If the physician inadvertently sends the employee's specimens to another laboratory, the employee will not receive their LabCard benefit.

II. UTILIZATION REVIEW

A. IMPORTANT NOTICE - PENALTY

Utilization review is a program which reviews the setting, necessity and quality of health care. We will furnish each individual with utilization review through Med-Cert**. MED-CERT'S PHONE NUMBER IS** 1-800-356-7126**.**

THE INDIVIDUAL IS RESPONSIBLE FOR MAKING SURE MED-CERT IS CONTACTED.
AUTHORIZATION FROM MED-CERT IS REQUIRED FOR:

- Inpatient Hospital Stays;
- Continuing Hospital Stays over 48 hours following vaginal delivery;
- Continuing Hospital Stays over 96 hours following a cesarean section;
- Outpatient Stays Over 12 Hours;
- Outpatient Surgeries;
- Healthcare Services And Supplies: Home Health Care; Hospice Care; Skilled Nursing Care.
- Physical Therapy; Occupational Therapy; Speech Therapy; after first six (6) visits.
- Diagnostic Services: MRI, PET and CAT Scan.

Utilization review is performed only for the purpose of reviewing the medical necessity of the above services for the care and treatment of an illness. **Authorization by Med-Cert does not guarantee that all charges are covered under the plan.** Charges submitted for payment are subject to all other terms and conditions of the plan.

As part of the utilization review process, Med-Cert will also review for alternate methods of medical care or treatment not otherwise listed as covered charges under the plan.

FAILURE TO CALL PENALTY: FAILURE TO PRE-CERTIFY AN ADMISSION WILL RESULT IN A REDUCTION OF 50% OF THE NORMAL PLAN BENEFITS FOR ALL CHARGES BY ANY PROVIDER RELATED TO THE IN-PATIENT HOSPITAL CONFINEMENT.

FAILURE TO PRE-CERTIFY EXTENSION BEYOND THE ORIGINAL PRE-CERTIFICATION PERIOD WILL ALSO RESULT IN REDUCTION OF 50% OF THE NORMAL PLAN BENEFITS FOR ALL CHARGES RELATED TO THE EXTENSION.

B. CERTIFICATION/PRE-CERTIFICATION

1. **Hospital Admissions:** The individual is responsible for making sure MED-CERT is notified of hospital stays before admission to a hospital as a bed patient. MED-CERT will review the Physician 's recommendation to determine whether a hospital stay is necessary or if the procedure can be safely performed on an outpatient basis. Hospital admission will include outpatient confinements which exceed 12 hours in length or which include overnight observation. If authorization for hospital admission is denied, no benefits will be paid for hospital charges.

2. **Outpatient Stays Over 12 Hours:** For any outpatient stay that extends beyond twelve (12) hours, the individual is responsible for making sure MED-CERT is notified within 48 hours. For outpatient confinement on a holiday, or after 5:00 p.m. on a Friday, or during a weekend, MED-CERT must be informed of the stay by the second business day. Benefits will be paid only for authorized stays. No benefits will be paid for outpatient stays not authorized.

3. **Outpatient Surgery:** The individual is responsible for making sure MED-CERT is notified **before** outpatient surgery is performed in other than a Physician 's office. MED-CERT will review the Physician's recommended course of treatment. No benefits will be paid for outpatient surgery not authorized.

4. **Emergency/Urgent/Hospital Admission:** For an emergency or urgent hospital admission, the individual is responsible for making sure MED-CERT is notified within 48 hours after admission. For admission on a holiday, or after 5:00 p.m. on a Friday, or during a weekend, MED-CERT must be informed of the admission by the second business day. Benefits will be paid for authorized days.
   - "Emergency hospital admission" means an admission for hospital confinement, which, if delayed, would result in a disability or death.
   - "Urgent hospital admission" means admission for a medical condition resulting from injury or illness which is less severe than an emergency admission but requires care within a reasonably short time. This includes pregnancy related conditions other than childbirth.

5. **Childbirth Related Admission:** Group health plans and health insurance issuers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).
   - Continuing Hospital stays over 48 hours following vaginal delivery. When a hospital confinement extends beyond forty-eight (48) hours following normal vaginal delivery, the individual is responsible for making sure MED-CERT is notified within 24 hours of the need for continued confinement.
   - Continuing Hospital stays over 96 hours following a cesarean section. When a hospital confinement extends beyond ninety-six (96) hours following a cesarean section, the individual is responsible for making sure MED-CERT is notified within 24 hours of the need for continued confinement.
   - Benefits for hospital confinements which exceed 48 hours following a vaginal delivery or which exceed 96 hours following a cesarean section will be paid only for authorized extended stays.

6. **Second Opinion -** A "second opinion" may be required for inpatient admissions or outpatient services. MED-CERT will inform the Physician if a second opinion is necessary. MED-CERT will explain to the individual requiring a second opinion which Physician's opinion will be acceptable.
   - A second opinion means an evaluation of the need for inpatient admission for outpatient treatment by a second Physician (or third Physician if the opinion of the Physicians conflict) including the Physicians exam of the patient and diagnostic testing.
   - A second opinion required by MED-CERT will be paid at 100% with no deductible.
   - If a second opinion was not approved by MED-CERT, benefits will be subject to the normal plan deductible and co-insurance factors.

7. **Healthcare Services and Supplies Review:** The individual is responsible for making sure MED-CERT is notified to obtain a plan of care approval for the following healthcare services and supplies: Home Health Care; Hospice Care; Skilled Nursing Care; Physical Therapy; Occupational Therapy; Speech Therapy. Benefits will be paid only for authorized healthcare services and supplies. No benefits will be paid for healthcare services and supplies not authorized, except that this requirement does not apply to the first six (6) visits for Physical Therapy; Occupational Therapy or Speech Therapy.

8. **Diagnostic Services:** The individual is responsible for making sure MED-CERT is notified **before** services are performed for the following non-emergency diagnostic tests: MRI, PET and CAT Scan. MED-CERT will review the Physician's recommended course of treatment. No benefits will be paid for non-emergency diagnostic tests listed above that are not authorized.

C. CONCURRENT REVIEW

After admission to the hospital, MED-CERT will continue to evaluate the patient's progress. If, after consulting with the Physician, MED-CERT determines that continued confinement is no longer medically necessary, the individual and the Physician will be advised. No benefits will be paid for hospital days not authorized.

D. RETROSPECTIVE REVIEW

MED-CERT will evaluate the medical records of those individuals whose medical treatment or hospital stay was not reviewed under Certification/Pre-Certification or Concurrent Review as described above.

If MED-CERT is unable to authorize any portion of the stay or treatment, the Physician will be contacted to provide additional information.

Benefits will be paid only for those days or treatment which would have been authorized. No benefits will be paid for any days or treatment not medically necessary.

E. CASE MANAGEMENT

Case Management is a program designed to assist the patient, their family and the attending physician in the development and coordination of an appropriate plan of care in the event of a catastrophic condition which requires specialized and/or long-term care.

Upon consultation with and approval by the patient and attending physician, the services of a case manager may include: Identification of alternative care options, monitoring of healthcare, assistance in obtaining needed healthcare equipment and services, and personal support to the patient and the family.

This is a voluntary program and there are no reductions of benefits or penalties if the patient and family choose not to participate. However, subject to the Plan Administrator’s approval, benefits may be payable for expenses authorized under a case management program which are not otherwise expressly covered under the plan.

III. SUMMARY OF BENEFITS

A. LIFE INSURANCE BENEFITS FOR EMPLOYEES

1. BASIC LIFE INSURANCE

In the event of your death while eligible under this Plan, your life insurance is payable to the person whom you have named as your beneficiary.

The life insurance portion of your coverage is provided by a commercial insurance carrier with whom your employer has contracted to provide the coverage. A booklet detailing this coverage is available upon request.

2. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT FOR EMPLOYEES

This portion of your coverage provides an additional death benefit in the event you suffer certain dismemberments or loss of sight due to accidental bodily injuries suffered through accidental means.

The life insurance portion of your coverage is provided by a commercial insurance carrier with whom your employer has contracted to provide the coverage. A booklet detailing this coverage is available upon request.

B. COMPREHENSIVE MEDICAL EXPENSE BENEFITS

1. COVERED EXPENSES

Covered Expenses are charges for the following services and supplies, which are certified by the attending Physician, or other appropriate covered Provider, to be necessary for treatment, to the extent that the charges do not exceed the Reasonable and Customary Amount:

1. **Allergy Services.** Medical care for allergy testing and allergen immunotherapy, including the provision and injection of allergenic extracts.

2. **Ambulance.** Local ground ambulance service to and from the nearest Hospital where care and treatment of the Injury or Illness can be given. Air ambulance will be covered up to a maximum of $2,000.00 per occurrence as long as such service is:
   (a) required to transport the covered person to the nearest hospital which provides the special medical treatment not available in the immediate area; and
   (b) ordered by a doctor; and
   (c) an aircraft used primarily for transporting sick and injured persons to the nearest hospital providing the necessary treatment.

3. **Ambulatory Surgery Center/ Birthing Center/ Urgent Care Center.** Medically necessary charges incurred in an ambulatory surgery center, lawfully operating birthing center, or urgent care center.

4. **Anesthesia.** Anesthetics and their administration, including the services of a C.R.N.A.

5. **Chiropractic Care.** Modalities (hot, cold therapy, etc.), manipulation and adjunctive therapy by a covered Provider to anatomically correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain are limited as stated in the schedule of benefits.

6. **Cosmetic Services.** Cosmetic Services are covered only when Medically Necessary for the following:
   a) Correction of a congenital birth defect for a Covered Person.
   b) Correction of conditions resulting from the prompt repair of a traumatic injury which is treated within 36 months of the injury and while the patient is covered under the Plan; or
   c) Reconstruction of breasts as part of a continuous treatment plan after a Medically Necessary mastectomy, including prostheses and physical complications of all stages of mastectomy, including lymphedemas, and surgery and reconstruction of the other breast to produce a symmetrical appearance.
   d) A breast reduction procedure, which is not subsequent to a mastectomy, will be covered when medically necessary to treat another medical condition(s) resultant from excessive breast size. Prior approval by the Plan is required. The participant must submit a request in writing to the Plan and must provide any medical records or other documentation as requested.

7. **Dental Expenses.** Charges will be covered for the following services:
   a) excision of tumors or cysts or incision or drainage of an abscess or cyst;
   b) excision of bony impacted teeth;
   c) treatment of accidental injury to sound natural teeth (including their replacement), provided treatment is completed within 6 months of the injury (breaking or chipping of a tooth while eating is not considered an accident);
   d) hospital services may be covered provided such services are Medically Necessary to safeguard the health of the Covered Person from the effects of a dental procedure due to a specific non-dental organic impairment.

   Diabetic Education Program. Benefits are provided for one diabetic program per Covered Person, per lifetime. Benefits are also provided for three education visits the first year and two thereafter. Follow-up visits in doctor's office are not covered. **Note:** The diabetes program must be certified by the American Diabetes Association. Services must be provided in a hospital-based outpatient education program.

8. **Diagnostic x-ray and laboratory services.** Charges for diagnostic laboratory and diagnostic x-rays, including electrocardiograms, basic metabolism tests, and similar diagnostic tests commonly accepted by Physicians throughout the United States.

9. **Dialysis Services and Supplies.** Dialysis services, including equipment rental, supplies, upkeep and training for you or your dependents to use this equipment.

10. **Electrical Bone Growth.** Any charges related to electrical bone growth stimulation must be approved by the Plan Administrator to be covered. A written request must be submitted to the Plan and must include any medical records or other documentation as requested.

11. **Home Health Care Expenses.** This part of the plan provides benefits for eligible charges for care furnished by a home health care agency. The benefits are subject to the following conditions:
   (a) The patient is under the care of a doctor who submits a "home health care plan" (a written program for care and treatment 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).
   (b) The services and supplies are furnished while inpatient confinement in a hospital, convalescent nursing home or skilled nursing facility would be required if it were not for the home health care.
   (c) the care is pre-certified and approved by Med-Cert.

The eligible expenses are the charges for the following services and supplies ordered by the doctor under the home health care plan and furnished in the patient's home.

(a) Part-time or intermittent nursing care provided or supervised by a Registered Nurse (R.N.).
(b) Part-time or intermittent home health aide services, primarily for the patient's care.
(c) Physical, occupational, speech or respiratory therapy by a qualified therapist.
(d) Nutrition counseling provided by or under the supervision of a registered dietician.
(e) Medical supplies, laboratory services, drugs and medications prescribed by a doctor.

The charges for the above will be considered in determining the amount to be paid under the plan. Charges for the services in item a, b, c, and d will be included to the extent that the charge for each home health care visit does not exceed the prevailing Medicare/Medicaid allowable charge. Not more than 100 home health care visits will be included in the eligible expenses for any one person in a calendar year. Each visit by a member of a home health care team is counted as one visit.

12. **Hospice Care.** Benefits are available under this provision when your Physician recommends in writing a hospice care plan on or before such hospice care is started, provided:
    a) the hospice care is for palliative care of a terminal illness (where life expectancy is less than 6 months); and
    b) you or your covered dependent elect (in writing) to follow the Physician's proposed treatment plan;

    This plan will pay benefits for all covered expenses incurred as part of the Hospice Care Plan for up to 31 days from the date it was established up to the maximum stated in the schedule of benefits.

    Benefits which are paid under this provision for any Covered Expense will not be duplicated under any other plan provision. These benefits are in lieu of any other plan coverage for treatment related to the terminal illness. Coverage under this provision ends if you elect (in writing) to discontinue hospice care or when the maximum benefit has been paid.

    Exceptions - Hospice care benefits are not payable for: Services provided by persons who do not regularly charge for their services; counseling which is not provided as part of the hospice care plan; services provided by homemakers, caretakers and the like; funeral expense; wills; estate planning; bereavement counseling for family members; or treatment intended to cure the terminal illness.

13. **Hospital Care**. Hospital room, board and general nursing care (excluding that part of the Hospital's charge for a private room which exceeds the Hospital's daily charge for its greatest number of two-bed rooms, and three times the average semi-private room rate for ICU or CCU), and charges for other Hospital services and supplies necessary for treatment of Injury or Illness, except services furnished by outside agencies and supplies not used while confined in the Hospital.

14. **Medical Equipment.** Charges for the rental, but not to exceed the purchase price, of Durable Medical Equipment (DME). At our option, the Plan may authorize the purchase of such DME in lieu of its rental if the rental price is projected to exceed the purchase price. Approval for purchase must be obtained in advance. Repair or maintenance of the DME is not considered a covered expense. No coverage is provided for duplicate DME rentals or purchases.

Durable Medical Equipment includes such items as an apnea monitor, braces, cervical collar, crutches, dialysis equipment, head halter, hospital bed, iron lung, non-motorized wheelchair, oxygen equipment, traction apparatus, ventilator, Continuous Passive Motion (CPM) devices and other items which meet the requirements indicated. However, only items which meet all the requirements below will be covered under the Plan.

Equipment which:

a) can stand repeated use; and,
b) can only be used to serve the medical purpose for which it is prescribed; and,
c) generally, is not useful to a person in the absence of an illness or an injury; and,
d) is appropriate for use in the home; and,
e) is basic, non-luxury, equipment; and,
f) is prescribed by a legally qualified Physician.

Benefits for Transelectrical Nerve Stimulation (TENS) devices are limited to 30 days of treatment for pain.

15. **Medical Supplies.** Benefits are payable for the following disposable or non-durable medical supplies:
    a) Blood and blood plasma, if not replaced.
    b) Casts, splints, trusses, or braces.
    c) Glucometers, dextrometers, destrostix, and infusion pumps (except as covered under the Prescription Drug Benefit)
    d) Initial post-mastectomy prosthesis and bra; bra limited to two per year.
    e) Lens (contact or glasses) when immediately following and which are medically necessary due to any eye surgery which is otherwise covered under this Plan.
    f) Ostomy/colostomy supplies and catheters
    g) Oxygen
    h) Surgical dressings and supplies, surgical hosiery, compression hosiery and pressure garment, and stump socks
    i) Total enteral or parenteral nutrition
    j) Injections administered by a Physician that are not otherwise excluded by the Plan

16. **Orthotics and Prosthetics**. Prosthetic appliances, which replace all or part of an absent body part and orthotic devices, which replace all or part of the function of a permanently inoperative or malfunctioning body part. The initial charge for any such appliance or device and any replacement due to pathological changes and normal growth shall be considered a covered expense. Shoe inserts or corrective shoes, except when custom made to fit a brace, are not covered.

17. **Physician's Fees**. Physician's fees for medical care and surgical operations which do not exceed the Reasonable & Customary Amount. No payment will be made for Physician visits on or after the day a surgical operation is performed if these visits are made by the Physician who performed or assisted in the surgery, or for more than one visit per day or by more than one attending Physician unless you are being treated for more than one diagnosis. Consultations will be allowed.

    - Assistant Surgeon - Charges for Medically Necessary services of an Assistant Surgeon (a physician who actively assists the surgeon in the performance of a covered surgical procedure), not to exceed 20% of the Reasonable & Customary Amount for the surgical procedure(s). No coverage is available for interns, residents, or facility staff members who assist.

    - Physician's Assistant - Charges for services provided by a Regulated Physician's Assistant. Physician's Assistants who actively assist the Surgeon in the performance of a covered surgical procedure will be covered up to 15% of the Reasonable & Customary Amount.

- **Registered Nurse Practitioner -** Charges for services provided by a Registered Nurse Practitioner.

18. **Podiatry.** Benefits for Podiatry care will be limited as stated in the schedule of benefits to payment of the following Covered Physician charges for diagnosis and treatment of:
    a) weak, strained, or flat feet or instability or imbalance of the feet;
    b) any tarsalgia, metatarsalgia or bunion other than operations involving the exposure of bones, tendons or ligaments; or
    c) toe nails (other than the removal of nail matrix or root) or the removal by cutting or any other method of superficial lesions of the feet including corns, calluses and hyperkeratosis.

19. **Prescription Drugs**. Charges for drugs that are prescribed in writing by a Physician, are Medically Necessary for the treatment of an Illness and/or Injury, and which are not otherwise excluded by the Plan. So long as the Prescription Drug Card Program is available under this Plan, only prescriptions obtained with the Prescription Drug Card will be covered. (Injectables that are administered by a Physician and which are not purchased through the Prescription Drug Card, will be covered under the Medical provision of the plan). See page 26 for specific limitations.

20. **Preventive Care Benefit**. Benefits for the following preventive services are payable up to the maximum stated in the schedule of benefits.

    a. Routine Screening Mammogram - Benefits are payable for routine screening mammograms.

    b. Routine Gyn Exam - Routine gynecological exam, including the associated pap smear, will be covered.

    c. Physical Exam - Expenses for routine physical exams and associated diagnostic tests are covered.

    d. Well Child Care. Expenses for routine health supervision, examinations and immunizations, are covered for children up to age 7.

    Preventive Care Benefits are not subject to satisfaction of the Plan Deductible.

    Neither the covered person's co-insurance amount nor any excess over the maximum amount covered will apply toward any deductible or co-insurance maximum.

21. **Private Duty Nursing.** Benefits are payable for Private Duty Nursing Services provided by an actively practicing Registered Nurse or a Licensed Practical Nurse. The service must be ordered by a Physician and skilled nursing care must be required. No benefits will be provided when the nurse usually lives in your home or is a member of your family. Private Duty Nursing Services include inpatient services when the nature and complexity of the condition cannot be rendered by the Provider's regular nursing staff or by Home Health Care services.

22. **R.N./L.P.N./L.V.N./Midwife/Nurse Midwife/Nurse Anesthetist**. Charges of a registered graduate nurse, practical nurse, or a licensed vocational nurse, who is either licensed as a practical nurse or is registered with an organization having the approval of the medical profession of medical care of Illness or Injury, provided the nurse is not related to the Covered Person either by blood or by marriage, by lineal descent or by any communal relationship; charges for services of a midwife, nurse midwife or nurse anesthetist acting within the scope of his or her license.

23. **Routine Nursery Care -** If you have dependent coverage, your Plan will cover routine nursery care while confined in a hospital. This includes nursery care, Physician charges and circumcision for well newborns incurred during the hospital confinement. Benefits are subject to the normal plan deductible and co-insurance limits.

24. **Skilled Nursing or Rehabilitation Facility Benefit.** Charges for Medically Necessary services, medicines, and supplies. The daily room benefit for a Skilled Nursing or Rehabilitation Facility can not exceed the most-common semiprivate rate of the last hospital in which you or your dependent was confined prior to confinement in the skilled nursing or rehabilitation facility. Benefits payable will be limited to a maximum of 100 days per calendar year. Eligible expenses must meet the following requirements:

    The Physician must certify that inpatient confinement in an acute care hospital would be otherwise required and that the medically necessary care may not be provided on an outpatient or home health care basis.

25. **Sleep Apnea.** Any charges related to the diagnosis or treatment of sleep apnea.

26. **Sterilization Procedures.** Charges for a voluntary sterilization procedure (e.g. tubal ligation or vasectomy) of a covered employee or dependent spouse, but excluding the reversal of these services.

27. **Therapy Services.**
    a) **Cardiac Rehabilitative Therapy.** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a medical care facility as defined by this plan.
    b) **Chemotherapy**. The use of chemical agents in the treatment and control of disease.
    c) **Occupational Therapy**. Occupational therapy by a registered/occupational certified therapist to restore physical function. Benefits are not provided for vocational training, educational services, or materials used in Occupational Therapy. PRE-CERTIFICATION IS MANDATORY for more than six visits.
    d) **Physical Therapy**. Services for treatment of an impaired bodily function, such as range of motion. Physical Therapy services must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. Massage therapy will be covered when part of a physical therapy treatment program and provided by a licensed Physical Therapist. PRE-CERTIFICATION IS MANDATORY for more than six visits.
    e) **Radiation Therapy**. Treatment with radioactive substances, including materials and services of technician.
    f) **Renal Dialysis Therapy**.
    g) **Respiration Therapy**. The introduction of dry or moist gases into the lungs.
    h) **Speech Therapy**. The treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital anomalies or previous therapeutic processes. PRE-CERTIFICATION IS MANDATORY for more than six visits. No benefits are provided for psychosocial speech delay or developmental delay or disorder.

28. TMJ/Jaw Joint Care. Any jaw (mandibular) augmentation or reduction procedures, or any procedures, restorations, or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome, myofascial pain syndrome or orthognathic treatment, including the correction of abnormal positioning and relationship of teeth are payable up to the limits stated in the schedule of benefits.

29. **Transplants.** Benefits for charges in connection with any covered transplant procedure, including donor charges, will be limited in the aggregate to the amount stated in the schedule of benefits. Charges incurred for transplant surgery will be considered under the following categories to allow for medically necessary care and treatment.

TYPE I - to be covered as any other illness:

- artery or vein transplants
- cornea transplants
- heart valve replacements
- implantable prosthetic lenses in connection with cataracts
- joint replacement
- prosthetic by-pass or replacement vessels

TYPE II - The following transplant procedures will be covered when such surgery is not considered Experimental or Investigational for the diagnosis/condition being treated.

- heart transplants
- pancreas
- heart/lung transplants, same donor
- liver transplants
- kidney transplants
- kidney/pancreas transplants, same donor
- single/double lung transplants
- autologous bone marrow transplants
- allogeneic bone marrow transplants
- other method(s) of stem cell support, by whatever name called.

All other transplants not specifically mentioned in Type I or Type II, which are considered Experimental or Investigational, will be excluded. No benefits will be paid for any charges associated with them. This includes, but is not limited to mechanical, artificial, and other than human transplants. A human-to-human organ transplant procedure which is not listed above, but which is not Experimental or Investigational treatment for the diagnosed condition being treated will be covered, subject to all provisions of this Plan.

Covered Organ Transplant Expenses Will Include:

a) Related services and supplies which are listed as Covered Expenses, under this Plan. Benefits will be payable subject to the Plan's provisions related to the specific Covered Expense. The maximum payable for all transplants and related services will be limited as stated in the Schedule of Benefits.
b) Donor Organ Procurement: (1) evaluation and surgical removal of donor organ; (2) transportation of the donor organ; (3) storage costs. If the scheduled transplant is canceled due to the patient's condition or death, and the organ cannot be used by another patient, procurement benefits will still be paid.

Organ Transplant Exclusions: The plan will not pay for: (a) services and supplies which are not directly related to the receipt of the organ; (b) artificial or animal organs; (c) the cost of the organ itself; (d) any organ transplant procedure which is Experimental or Investigational for the diagnosis or condition being treated; (e) any expenses when approved alternative remedies are available; (f) any financial consideration to the donor other than for a covered expense which is incurred in the performance of or in relation to transplant surgery; (g) any non-covered expense, as described in the Limitations and Exclusions section of this Plan.

2. LIMITATIONS AND EXCLUSIONS

These provisions apply to all Benefits payable under the plan.

a. PREMATURE BABY LIMITATION

Coverage will be as for any other condition during the baby's first year of life provided the mother has complied with the following requirements:

1. the mother must have received six (6) prenatal visits, the first of which must have been incurred during the first trimester;
2. there must be no evidence of illegal drug use during the prenatal period;
3. the mother must have followed the physician's recommended medical advice; and
4. the mother must provide documentation satisfactory to the Plan Administrator regarding 1, 2, and 3.

If the mother has not satisfied these requirements, there will be a limitation on reimbursement for a newborn baby of $50,000.00 during the baby's first year of life.

b. PRE-EXISTING CONDITIONS EXCLUSION

A Pre-Existing Condition is a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6 months period prior to the Enrollment Date.

The following will not be subject to any Pre-Existing limitations or exclusions under the Plan:

- Genetic status in the absence of a diagnosis of the condition related to the genetic information; or
- Pregnancy, under any circumstance; or
- A newborn or newly adopted child provided you enroll the child covered under the Plan within 30 days of birth, adoption, (or the date on which the child is placed with you for adoption, whichever is earlier), or who has Creditable Coverage from birth, adoption, or placement for adoption without a 63-day break in Coverage.

Benefits for claims resulting from Pre-Existing Conditions are excluded from coverage under the Plan except as specified below:

If the Covered Person is covered under the Plan for a period of time equal to twelve (12) consecutive months from the Enrollment Date minus the Covered Person's period of Creditable Coverage, the pre-existing condition exclusion will no longer apply.

c. EXCLUSIONS

Benefits will not be payable for any of, but not strictly limited to, the following:

1. **Abortion** - Any charges associated with abortion procedures or pregnancy-related conditions resulting in abortion unless such procedures are medically necessary to protect the life of the mother in the opinion of two legally qualified Physicians, or the pregnancy is the result of rape or incest. However, this exclusion will not apply to medical complications arising from or after a non-covered abortion procedure.

2. **Alternative Treatment -** Charges for acupuncture, hypnosis, aromatherapy, rolfing, and other forms of alternative treatment as defined by the Department of Complementary and Alternative Medicine of the National Institute of Health.

3. **Alcohol/ Chemical Dependency/ Drug Abuse -** Medications or other prescription drugs used by an Outpatient to maintain an addiction or dependency on drugs, alcohol or chemicals. Also excluded are services, supplies, or other care associated with the treatment of Chemical Dependency in the event the Covered Person fails to comply with the plan of treatment.

4. **Behavioral Training and Modifications -** Services, supplies, or other care for job training, scholastic improvement, or behavioral problems in the absence of a diagnosed mental illness or disorder. Also excluded are services, supplies, or other care for non-chemical addictions such as gambling, sexual, spending, shopping and working addictions, co-dependency, nicotine, or caffeine addiction, milieu therapy, marriage counseling, vocational rehabilitation, sensory integration, educational therapy and recreational therapy, except for adjunct services as part of an inpatient confinement and as required by the Joint Commission on Accreditation of Healthcare Organizations.

5. **Cardiac Rehabilitation - Inpatient** - Charges incurred for services, supplies, or other care provided to an Inpatient solely for cardiac rehabilitation.

6. **Chelation Therapy/ Massage Therapy** - Charges for chelation therapy, except in the treatment of lead or other heavy metal poisoning, or charges for massage therapy (except as provided under physical therapy).

7. **Childhood Disorders** – Treatment of learning disorders, behavioral problems, mental retardation, hyperkinetic syndrome, or autism of childhood.

8. **Civil Disturbance / Crime -** Charges incurred as the result of participation in a riot or civil disturbance or while committing or attempting to commit an assault, felony, or misdemeanor (other than traffic violations) or taking part as a principal or as an accessory in illegal activities or an illegal occupation.
   Charges resulting from an illness or injury incurred while under the influence of alcohol or illegal drugs as evidenced by a blood alcohol level equal to or in excess of the legal amount allowed in the state where the injury occurs or any other drug or alcohol screening test.
   Charges incurred for care required while incarcerated in a federal, state, or local penal institution or while in custody of federal, state or local law enforcement authorities, including work release programs.
   Also excluded are any charges incurred due to complications relating to or resulting from these conditions or services.

9. **Contraceptives** - Injections, implants, devices or the fitting of devices or any other service or supplies provided for birth control purposes.

10. **Cosmetic Services** - Charges incurred for any treatment for cosmetic purposes and/or complications arising directly from the cosmetic services. Cosmetic services means procedures performed to improve a Covered Person's appearance or to correct a deformity without restoring physical bodily function, except as specifically listed under Covered Expenses. The presence of a psychological condition will not entitle a Covered Person to coverage of cosmetic services.

    Excluded services include, but are not limited to, removal of tattoos, scars, wrinkles or excess skin; plastic surgery; silicone injections or implants; electrolysis; wigs, including those used as cranial prostheses; hair pieces or hair transplants; treatment of male pattern baldness; correction of breast size or disproportion/dyssymmetry (except following mastectomy); revision of previous elective procedures; removal of keloids; pharmaceutical regimes; nutritional procedures or treatments; rhinoplasty; epikeratophakia surgery; and skin abrasions performed for the treatment of acne.

11. **Court Ordered Care** – Any care, confinement or treatment provided as a result of a court order.

12. **Custodial Care/ Educational Care** - Charges incurred for custodial care, or care rendered in rest homes, health resorts, homes for aged or places primary for domiciliary or custodial care. Custodial Care means that care which is designed primarily to assist an individual in meeting the activities of daily life, such as help in walking or getting out of bed, personal care such as bathing, dressing, eating, or preparing special diets, or taking medications. Also excluded are charges incurred for education, training, or room and board which is provided by an institution which is primarily an institution of learning or training, including treatment for scholastic improvement, vocational training, motor coordination, learning disabilities or behavioral problems. Charges for any expenses for training, educational instruction, or educational materials, unless otherwise specified in the Plan, and charges for services, supplies, or other care for educational or training procedures used in connection with speech, hearing or vision.

13. **Dental Services -** Charges incurred for any treatment of teeth or gums or for any treatment in connection with the fitting or wearing of full or partial dental prostheses (fixed or removable).
    This exclusion does not apply to:
    a) excision of tumors or cysts or incision or drainage of an abscess or cyst;
    b) excision of bony impacted teeth;
    c) treatment of accidental injury to natural teeth (including their replacement), provided treatment is completed within 90 days of the injury (breaking or chipping of a tooth while eating is not considered an accident);
    d) hospital services may be covered provided such services are Medically Necessary to safeguard the health of the Covered Person from the effects of a dental procedure due to a specific non-dental organic impairment.

14. **Disposable Supplies/ Personal Services** - Charges incurred for normal home medical supplies or first aid items provided to an outpatient, including but not limited to, ace bandages, and elastic stockings. Also excluded are charges for services or supplies which constitute personal comfort or beautification items, television or telephone use, or rest cures.

15. **Donor Charges -** Charges incurred for any services, supplies, or other care which are rendered to any person who requires them by reason of acting as a donor of any non-covered organ or element of the body, or services or supplies rendered to any individual who is not a covered Participant, except as provided under the donor procurement provision.

16. **Drugs** - Drugs, except insulin, which could be purchased without a written prescription. (So long as the Prescription Drug Card Program is available under this Plan, out-patient prescription drugs are excluded except as provided under the Prescription Drug Card Benefit, or for the first 30 days of enrollment or after the Prescription Drug Cards have been distributed, whichever occurs first).

17. **Durable Medical Equipment/ Prosthetic Appliances/ Orthotic Devices** - Charges for corrective shoes or orthopedic devices/orthotics, except for an initial pair of shoes when custom made to fit a brace; purchase or rental of escalators or elevators; spas or saunas; blood pressure kits; penile implants; modifications to a home or place of business, such as ramps, air conditioners, seat lift chairs, or supplies for any of these items; adjustments made to vehicles, air purifiers, humidifiers, stair-glider, Emergency Alert equipment, handrails, heat appliances, waterbeds, whirlpool baths, hydrocollators, hot packs, diathermy, infra-red, Hubbard Tank, cold packs, ice packs, and contrast baths.

18. **Employment-Related Conditions / Workers' Compensation -** Charges incurred as the result of or in connection with any activity pertaining to any act of employment for profit, gain, or compensation for which you receive a W-2 or 1099 from an employer, or for which you file a self-employment schedule for federal income taxes; or charges incurred as the result of a disease, illness, or condition for which benefits are payable under any Workers' Compensation Act, any Occupational Diseases Act or any other similar such benefit program.

19. **Exercise Equipment / Health Clubs** – Exercising equipment, massage or vibratory equipment, swimming or therapy pools, enrollment in health, athletic or similar clubs, or services, or supplies used for physical fitness, athletic training, or general health upkeep.

20. **Experimental/ Investigational Services** - Charges for services, supplies or other care which are considered Experimental or Investigational as defined by this Plan (including organ transplant or mechanical organ implantation, except as provided under the transplant provision of this Plan). (Please refer to the definition of Experimental/ Investigational.)

21. **Family Member/Resident Provider** - Charges incurred for services, supplies or other care rendered by a provider who is a member of the Covered Person's immediate family, or who resides in the Covered Person's household.
(Immediate family includes you, your spouse, child, brother, sister, parent, or in-law of you or your spouse).

22. **Governmental Health Plans -** Except as required by law, charges for services or supplies furnished in any institution or facility operated by the United States government, any state government, or by any agency or instrumentality of such government. This exclusion does not apply to treatment of non-service related disabilities or for inpatient care provided in a military or other Federal Government Hospital to dependents of active duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where otherwise prohibited by law.

23. **Hazardous Material** – Expenses incurred as a result of radioactive contamination or the hazardous properties of nuclear material.

24. **Hearing Related Services** - Charges incurred for routine hearing tests and audiograms not performed in connection with a disease, illness, or injury, or for hearing aids, the fitting of hearing aids , or Cochlear Implant devices and implant procedures.

25. **High Risk Activities -** Care and treatment of any Injury or Sickness that results from engaging in a Hazardous activity. An activity is hazardous if it is an unusual activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies are skydiving, auto racing, hang gliding, motorcycle or ATV operating, jet ski operating, snowmobiling or bungee jumping.

26. **Hospice Care** - Hospice care benefits are not payable for: services provided by persons who do not regularly charge for their services; counseling which is not provided as part of the hospice care plan; services provided by homemakers, caretakers and the like; funeral expense; or treatment intended to cure the terminal Illness.

27. **Infertility/ Fertility** - Charges incurred for fertility or infertility studies or treatment including but not limited to: artificial insemination, in vitro fertilization, hormone therapy to cause pregnancy, embryo therapy, embryo transport, gamete intra-Fallopian transfer, gamete/zygote embryo transfer, donor semen or eggs, gamete transfer, HLA typing (human leukocyte antigen), sperm banking, other assistive reproductive services, or reversal of elective sterilization procedures, and charges related to surrogate pregnancies.

28. **Lipectomy/ Diastasis Recti Repair** - Charges incurred for services or supplies related to suction-assisted lipectomy or diastasis recti repair, including instances when diastasis recti is associated with an umbilical or ventral hernia.

29. **Maternity Related Expenses** - Charges which are related to pregnancy or resulting childbirth of anyone other than a covered female employee or the covered wife of a male employee. No benefits are payable for any charges related to pregnancy <u>or</u> resulting childbirth of other dependents. Charges incurred for any ultrasound, echogram, or amniocentesis procedures related to pregnancy unless such procedure is necessitated by a complication of pregnancy. Testing for the purpose of fetal age or sex or solely because of maternal age shall not be considered a complication of pregnancy. Exception: One routine ultrasound per pregnancy will be considered a covered expense.

30. **Mental Health Services/Chemical Dependency** - Any charges for treatment of or conditions related to neurosis, psychosis, personality, or other mental or nervous disorders or chemical dependency.

31. **Military Service/ War Injuries -** Charges incurred as a result of military service for any country or organization, including service with military forces as a civilian whose duties do not include combat. Charges incurred for treatment of injury, illness or other condition which is occasioned by war, declared or undeclared.

32. **Motor Vehicle Accidents** - Charges incurred due to injuries received in an accident involving any motor vehicle for which there is in effect, or is required to be in effect, any policy of no-fault insurance. This exclusion is not applicable to expenses not paid by any required policy of no-fault insurance as a result of state required policy deductibles or maximums.

33. **Newborn Care** - Charges incurred for usual and ordinary inpatient nursery and pediatric care of a well newborn child except those charges incurred during the length of the mother's stay.

34. **Non-Covered/ Non-Medical Services -** Charges incurred for any services, supplies, or other care which are not specifically listed as covered expenses under this Plan.
    a) Charges incurred due to complications resulting from any treatment, services or supplies which are specifically excluded under this Plan.

b) Charges incurred for any services, supplies or other care for personal hygiene, environmental control, or convenience items, or charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form, or charges for travel or accommodations, whether or not recommended by a Physician.
c) Charges for benefits that are not payable due to the application of any specified deductible or co-payment provisions contained herein
d) Charges by a non-covered Provider
e) Charges incurred before coverage began or after coverage terminated, or which are in excess of the limits specified in the plan.

35. **Not Medically Necessary** - Charges for services, supplies or other care which are not Medically Necessary for the diagnosis or treatment of a physical or mental Illness, injury, or symptomatic complaint (Please refer to the definition of Medically Necessary.); or,
    a) Services, supplies, treatment, or any care which is not rendered for the treatment and correction of a specific Illness, or condition, or accidental bodily injury, or which is incurred while the Covered Person is not under the direct care of a Physician; or,
    b) Hospital care and services rendered after the patient has been discharged from the Hospital by the attending Physician, or for Hospital care and services when a registered bed patient is absent from the Hospital; or,
    c) When in the judgement of the Administrative Manager (or such person, persons or group designated by him) the medical or surgical services did not require the acute Hospital overnight setting, but could have been provided in a Physician's office, the outpatient department of a Hospital, or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered, including but not limited to admissions primarily for observation or evaluation and/or diagnostic studies that could have been provided safely and adequately on an outpatient basis, or admissions to control or change the patient's environment.
    d) The fact that a Physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it Medically Necessary or make the charge a covered expense even though it is not specifically listed as an exclusion.

36. **Non-Timely Claim Submission** - Charges submitted more than **180 days** after the charges were incurred or information necessary to process the claim was first requested from the Covered Person.

37. **No Obligation To Pay Services -** Charges incurred for which the Covered Person has no legal obligation to pay in the absence of this or similar coverage, or for which no charge has been made. Where Medicare coverage is involved and this Plan is a secondary coverage, this exclusion will apply to those amounts which a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.

38. **Nutritional Services** - Charges incurred for food supplements (except enteral or total parenteral nutrition), minerals, vitamins, or other dietary supplements.

39. **Obesity** - Charges incurred for services, supplies, surgery, or other care or programs rendered for the purpose of weight loss, regardless of its classification, even if the individual has other health conditions which might be helped by weight reduction, or charges incurred for the removal of excess fat or skin following weight loss.

40. **Outside United States or Canada -** Charges incurred outside the United States or Canada, if the charges are incurred for the primary purpose of obtaining medical services, drugs, or supplies.

41. **Physical Exams/ Immunizations** - Charges for immunizations or other care for routine physical examinations (except as otherwise specified under Covered Expenses), preventive medicines, vitamins, minerals or other dietary supplements, or vaccinations whether or not prescribed by a doctor. (This includes well baby care and routine check-ups except as otherwise provided in the plan.) Tests for screening purposes or which are required by third parties such as; for employment, licensing, travel, school, insurance, marriage, adoption, participation in athletics, or services conducted for medical research, or an examination required by a court.

42. **Physicians' Visits/ Stand-by Charges** - Charges incurred for inpatient Physicians' visits in excess of one each day if surgery is not required, or for Physicians' visits on or after the day of surgery, unless there is more than one diagnosis being treated; Charges for services by a covered practitioner which are not within the scope of his/her license; or, Stand-by charges by a surgeon or pediatrician.

43. **Reasonable and Customary Charges** - Charges which exceed the Reasonable and Customary Amount or which are excessive. Please refer to the Plan's definition of Reasonable and Customary Amount.

44. **Self-destructive/ Self-inflicted Injuries** - Charges incurred as the result of any self-destructive act or intentionally self-inflicted injury, illness, or condition, including but not limited to any subsequent or consequent therapy or treatment related thereto, except when injury results from a medical condition, either physical or mental.

45. **Sexual Transformation/ Sexual Dysfunction** - Charges incurred for services, supplies, or other care related to sex transformation, sexual dysfunctions, inadequacies, or charges related to impotency, including penile implants.

46. **Smoking Deterrents** - Charges for drugs or supplies, both inpatient or outpatient.

47. **Sterilization reversal charges** – Charges incurred in connection with surgical procedure to reverse (a) a vasectomy or (b) a sterilization tubal ligation.

48. **Third Party Responsibility -** Charges which are or which may become the responsibility of any third party. However, the Administrative Manager has been authorized by the Plan to pay provisional benefits when the beneficiary and their legal counsel, if any, have executed a Subrogation Agreement form which is satisfactory to the Administrative Manager. Refer to the Plan provisions regarding Subrogation of Benefits and Right of Recovery.

49. **Vision Care** - Charges incurred for vision care, including eyeglasses or contacts (unless otherwise specified in this Plan), including but not limited to refractive surgery, radial keratotomy, keratomileusis, or lasik surgery.

SHOULD THE PLAN PAY BENEFITS AND IT IS LATER DETERMINED THAT SUCH BENEFITS SHOULD NOT HAVE BEEN PAID BASED ON THE EXCLUSIONS MENTIONED ABOVE, THE PLAN EXPLICITLY RESERVES THE RIGHT TO RECOVER ANY AND ALL BENEFITS PAID IN ERROR.

YOU, YOUR BENEFICIARY, OR A DULY AUTHORIZED REPRESENTATIVE MAY APPEAL ANY DENIAL OF A CLAIM FOR BENEFITS BY FILING A WRITTEN REQUEST FOR REVIEW TO THE PLAN ADMINISTRATOR WITHIN 180 DAYS AFTER RECEIPT OF THE WRITTEN NOTICE OF DENIAL OF A CLAIM. PLEASE REFER TO THE CLAIMS REVIEW AND APPEAL PROCEDURES UNDER SECTION X. OF THE PLAN.

C. PRESCRIPTION DRUG CARD BENEFIT

Benefits are payable for out-patient prescription drugs obtained with a drug card only or through the mail order program only.

Prescription drugs are drugs and medicines lawfully obtainable only upon the written prescription of a Physician and include the following covered drugs:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medication
- OTC Diabetic Supplies
- Insulin
- Needles and Syringes on Prescription Only
- Retin-A (up to age 25 only)

The following are <u>excluded</u> from coverage unless specifically listed above as a covered drug:

- ALL contraceptive devices and medications
- Non-Federal Legend Drugs
- Therapeutic devices or appliances
- Fertility medications
- Smoking Deterrents
- Allergy Serum
- Amphetamines
- Anorexiants
- Legend Vitamins
- Fluoride Products
- Medications related to sex transformation, sexual dysfunctions or inadequacies, sexual enhancement
- Drugs whose sole purpose is to promote or stimulate hair growth.
- Drugs labeled "Caution-limited by Federal Law to investigational use", or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Worker's Compensation or Occupational Disease law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceutical, as these charges are covered under the Medical provision of the Plan or are otherwise excluded.
- Any prescription refilled in excess of the number of refills specified by the Physician, or any refill dispensed after one year from the Physician's original order.

Dispensing Limits:

- **Mail Service:** The amount of drug including Insulin which is to be dispensed per prescription or refill will be in quantities prescribed up to a 90 day supply. One Year of Refills is covered.
- **Retail:** The amount of drug (including Insulin) which is to dispensed per prescription or refill will be in quantities prescribed up to a 30 day supply. One year of refills is covered.

Benefits are subject to the co-payments as outlined in the Schedule of Benefits. This benefit is not subject to the satisfaction of the Plan deductible.

D. DENTAL BENEFITS- (If Eligible)

Calendar year deductible – Class B & C only.
Per individual.. $50.00
Per family $150.00

Calendar year deductible – Class D only.
Per individual..$100.00

% Payable
Class A – Preventive 100%
Class B – Basic 80%
Class C – Major.. 70%
Class D – Orthodontia.. 50%

Maximum Benefits Payable:
Annual Maximum Benefit (Class A, B, and C combined) $1,250.00
Lifetime Maximum Benefit (Class D)... $1,000.00

A. COVERED DENTAL EXPENSES

The term "Covered Dental Expenses" refers to the items of dental expense for which dental benefits may be payable. Covered Dental Expenses are charges for the following services and supplies, which are certified by the attending Dentist or Physician to be necessary for the treatment of a dental condition, to the extent that the charges do not exceed the usual charge of the Dentist or Physician and the reasonable and customary charges generally made in the same locality under similar conditions:

Class A – Preventive Procedures

1. Routine oral examinations, but not more than once during any six consecutive months.
2. Topical application of fluoride for Dependent children under 16 years of age, but not more than once during any 12 consecutive months.
3. Space maintainers that replace prematurely lost teeth for Dependent children under 16 years of age. Repairs to space maintainers are not covered.
4. Dental x-rays, including full mouth x-rays, but not more than once in any period of 60 consecutive months;
5. Supplementary bitewing x-rays, for dependent children under age 19, only one set will be covered in any six consecutive months; bitewing x-rays for adults 19 years of age or older, only one set will be covered in and 12 consecutive months; and such other dental x-rays required in connection with the diagnosis of a specific covered condition which requires treatment.
7. Prophylaxis (cleaning of teeth), but not more than once in any six consecutive months.
8. Topical application of sealant applicable only to first and second permanent molars for dependent children under age 16. Limited to one treatment per tooth in any 36 consecutive months.
9. Harmful habit appliance; limited to one time per person under the age of 16.

Class B – Basic Procedures

1. Extractions
2. Oral Surgery
3. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration to restore diseased or fractured teeth.

Replacement of existing fillings are covered only if at least 24 consecutive months have passed since placement of prior filling, unless required by new decay in an additional tooth surface. Multiple restorations on one surface will be paid as a single filling.

4. Stainless steel crown
5. Alveoloplasty
6. Removal of dental cysts and tumors
7. Surgical incision and drainage of dental abscess
8. Surgical exposure to aid eruption
9. Excision of hyperplastic tissue
10. Scaling and root planning (each quadrant). Covered once each quadrant in any 24 consecutive months.
11. Periodontal appliance. One appliance is covered in any 36 consecutive months.
12. Periodontal prophylaxis (including probing, charting, exam, polishing, scaling, root planning and similar maintenance procedures). Covered only if at least three months have elapsed after completion of active therapeutic scaling and root planning or active surgical periodontal treatment and then not more than once in 12 consecutive months.
13. Vital pulpotomy. Covered for deciduous teeth only.
14. Emergency exam. Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.
15. Consultation with specialist. Covered once in any 12 consecutive months.
16. Antibiotic drug injection
17. Biopsy of oral tissue
18. Palliative treatment. Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.
19. Bacteriologic culture
20. Histopathologic examination
21. General anesthesia when medically necessary and administered in connection with oral or dental surgery.
22. Treatment of periodontal or other diseases of the tissues of the mouth.
23. Endodontic treatment, including root canal therapy.

Class C – Major Procedures

1. Periodontal Surgical Procedures – Including ginigival flap prodecure, gingivectomy. gingival curettage. osseous surgery. pedicle soft tissue graft, and free soft tissue graft. Only one of the listed periodontic surgical procedures is covered for each quadrant in any 24 consecutive months.
2. Recementing of crowns, inlays, onlays, or bridgework. Covered only if done more than 12 months after initial insertion of inlay, only, crown, or bridge, and then not more than one time in any 24 consecutive months.
3. Repairs to complete or partial denture, bridge, or crown. Covered only if repair is done more than 12 months after initial insertion of denture, bridge, or crown, and then not more than one time in any 24 consecutive months.
4. Relining or rebasing complete or partial dentures. Covered only if relining or rebasing is done more than 12 months after initial insertion of the denture and then not more than one time in any 24 consecutive months.
5. Tissue conditioning. Covered only if at least 12 months have elapsed since the insertion of a complete or partial denture and not more than once in any 24 consecutive months.
6. Denture adjustment. Covered once in any 12 consecutive months and only is at least 12 months have elapsed since the insertion of the denture.

7. Inlays and onlays. Inlay or only restorations are covered only if the tooth cannot be restored by a filling and (for replacements) at least 84 consecutive months have elapsed since the last placement.
8. Labial veneer. Veneer restorations are covered only if the tooth cannot be restored by a filling ad (for replacements) at least 84 consecutive months have elapsed since the last placement.
9. Crowns (single restorations only). Crowns are covered only if the tooth cannot be restored by a filling and (for replacements) at least 84 consecutive months have elapsed since the last placement. Crowns for the primary purpose of splinting, altering, or maintaining vertical dimension, or restoring occlusion are not covered. Crowns for the replacement of veneer, inlay or onlay are covered only if at least 84 consecutive months have elapsed since the last placement of the restoration. Crowning of implant replacing a tooth missing prior to the effective date is not covered. For persons under 16 years of age, the benefit for crown on vital teeth are limited to resin or stainless steel crowns.
10. Cast post and core. Covered only for teeth that have had root canal therapy.
11. Steel post and composite or amalgam. Covered only for teeth that have had root canal therapy.
12. Fixed bridges – initial placement or replacement. Initial placement of fixed bridges to replace teeth which were missing prior to the effective date of the insured person's coverage will not be covered unless it includes the replacement of a functioning natural tooth extracted while the person is insured under the group policy (provided that tooth was not an abutment to an existing partial denture that is less than 60 months old). In that event, benefits are payable only for the replacement of those teeth which were extracted while insured under the group policy. Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than 84 consecutive months old and is not serviceable and cannot be repaired.
13. Complete or partial dentures – initial placement or replacement. Initial placement of complete or partial dentures to replace teeth which were missing prior to the effective date of the insured person's coverage will not be covered unless it includes the replacement of a functioning natural tooth extracted while the person is covered under the group policy. In that event, benefits are payable only for the replacement of those teeth which were extracted while insured under the group policy. Benefits for the replacement of an existing complete or partial denture are payable only if the existing denture is more than 60 consecutive months old and is not serviceable and cannot be repaired. Covered charges for complete or partial dentures do not include any additional charges for overdentures or for preceision or semiprecision attachments.

Class D – Orthodontia (for dependent children only)

Formal, full-banded retention and treatment, including x-rays and other diagnostic procedures. Removable or fixed appliances for tooth or bony structure guidance or retention.

B. DENTAL LIMITATIONS AND EXCLUSIONS

Benefits will not be payable under the Plan for:

1. Treatment or service that is not necessary dental care; or
2. any part of a charge for treatment or service that exceeds the prevailing charges; or
3. the services of any person who is not a Dentist or Dental Hygienist; or
4. the services of any person in you immediate family or any person in your dependent's immediate family; or

5. personalization of dentures or crowns (or any other treatment that is primarily cosmetic); or
6. treatment or service that does not meet professionally recognized standards of quality; or
7. implants; or
8. drugs or medicines (other than antibiotic injections); or
9. instructions for plaque control, oral hygiene, or diet; or
10. bite registration or occlusal analysis; or
11. treatment or service to alter or maintain vertical dimension or restore or maintain occlusion; or
12. treatment or service to duplicate or replace a lost or stolen prosthetic device or to duplicate or replace a lost or stolen appliance; or
13. treatment or service for provisional or permanent splinting; or
14. orthodontic treatment or service received within 24 months after your dependent child's dental expense coverage is effective, unless the appliance or bands were first inserted on or after the effective date; or
15. treatment or service that results:
    - from any injury arising out of or in the course of any employment for wage or profit if the member or dependent is eligible to be covered under a Workers' compensation Act or other similar law; except that this limitation will not apply to partners, proprietors, or corporate officers who are not covered by a Workers' Compensation Act or other similar law; or
    - from a sickness covered by a Worker's Compensation Act or other similar law; or
16. treatment or service that is temporary; or
17. treatment or service replacing tooth structure lost from abrasion or attrition; or
18. treatment or service which may not reasonable be expected to successfully correct the patient's dental condition for a period of at least three years; or
19. treatment or service provided outside the Untied States, unless you or your dependent are outside the United States for one of the following reasons;
    - travel, provided the travel is for a reason other than securing dental care diagnosis or treatment, and travel is for a period of six months or less; or
    - a business assignment, provided you or your dependent are temporarily outside the United States for a period of six months or less; or
    - full-time student status, provided the student is either:
    - enrolled and attending an accredited school in a foreign country; or
    - is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit; or
20. treatment or service for which you or your dependent have no financial liability or that would be provided at no charge in the absence of insurance; or
21. treatment or service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or other medical assistance plans for the needy or indigent or as required under Federal law); or
22. treatment or service that results from war or act of war; or
23. treatment or service that results from participation in criminal activities.
24. Charges for any dental services if benefits or services for all or any part of the expenses for such services are provided under the group employee benefit or prepayment plans providing hospital, surgical and medical services or benefits;

E. VISION CARE BENEFITS

Calendar Year Deductible... None
Percent Payable.. 50%
Maximum Benefits Payable... $225.00 per calendar year

Vision care benefits are payable for Covered Vision Care Expenses, subject to the limitations listed below, when services and/or supplies are recommended by a Physician or an Optometrist.

Covered Vision Care Expenses **Frequency Limitation**

Vision Exam .... Once every 12 months

Prescription lenses or contact lenses, or
12 months supply of disposable contact lenses. .... Once every 12 months

Frames... Once every 24 months

Excluded Vision Care Expenses

No benefits are payable for:

1. Medical or surgical treatment of an eye injury or eye disease
2. Charges covered under any other provision of this Plan
3. Any expenses, other than Vision Care, which are excluded or limited under the Comprehensive Medical Benefits provision of this Plan
4. Charges for orthoptics (eye muscle exercises), vision training or subnormal vision aids
5. Charges for lenses which can be purchased without a prescription

F. LAB CARD BENEFIT

Outpatient laboratory charges billed by LabCard.. 100%

Outpatient laboratory services billed by LabCard are payable at 100%. In order for employees to have their lab work performed at no cost to them, their lab work must be sent to LabCard for testing. The employee must inform their physician's office that their lab specimens are to be sent to LabCard to ensure that their specimens are not mistakenly sent to another reference laboratory. Employees should show their Healthcare I.D. Card at their physician's office when they check in, and let the office personnel know that they intend to use LabCard for their lab work. Employees should also remind whoever is collecting their specimens that their specimens need to be sent to LabCard for testing. If the physician inadvertently sends the employee's specimens to another laboratory, the employee will not receive their LabCard benefit.

IV. DUPLICATION OF BENEFITS

A. COORDINATION OF BENEFITS

Benefits provided under this Plan are subject to this Coordination of Benefits (COB) provision. This Provision shall apply to all benefits provided under this Plan, except for benefits provided under a Prescription Drug Card Benefit of this or any other Plan, other than as required by law for claims subject to Medicare Part D and Medicare secondary payor requirements.

1. DEFINITIONS

DEFINITIONS in this provision are as follows:

a. "PLAN" means any Plan providing benefits or services for or by reason of medical care or treatment, which benefits or services are provided by (i) group, blanket, or franchise insurance coverage, (ii) Blue Cross, Blue Shield group practice, and other prepayment coverage (iii) any coverage under labor management trusted plans, union welfare plans, employer organization plans, or employee benefit organization plans, (iv) any coverage under governmental programs or any coverage required or provided by statute, excluding Medicaid and (v) any individual health plan.

   The term "Plan" shall also mean any mandatory automobile reparations insurance (no-fault) providing benefits under a medical expense reimbursement provision for hospital, medical, or other health care services and treatment because of accidental bodily injuries arising out of a motor vehicle accident, and any other medical and disability benefits received under any automobile policy where and to the extent that coordination of such benefits is permitted by law.

   However, the definition of "Plan" does not include paragraph A.(l) (iv) above when:
   (1) the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and/or the Deficit Reduction Act of 1984 (DEFRA) and/or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to an Employee or Dependent; and
   (2) the Employee or Dependent has elected this Plan as primary coverage.

   The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take the benefits or services or other Plans into consideration in determining its benefits and that portion which does not.

b. "ALLOWABLE EXPENSES" means any necessary, reasonable and customary item of expense, at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made or service provided.

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

c. "CLAIM DETERMINATION PERIOD" means calendar year.

2. EFFECT ON BENEFITS

a. This Provision shall apply in determining the benefits as to a Covered Person under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such Covered Person during such period, the sum of:
(1) the benefits that would be payable under this Plan in the absence of this provision; and
(2) the benefits that would be payable under all other plans in the absence therein of provisions of similar purpose to this provision
would exceed the Allowable Expenses.

b. Non-Duplication of Coverage-
When coordination of benefits is applicable, benefits will be determined as follows:
1st- The amount payable under this plan is determined.
2nd- The amount paid by the primary plan is determined.
3rd- The amount paid by the primary plan is subtracted from the amount payable under this plan.

Example:

	This Plan	Primary Plan
Charge-	$500	$500
Deductible	-$300	-$400
Balance	$200	$100
x	80%	80%
	$160	$ 80

$160 - $80 = $80.00 Benefit Payable

c. If:
(1) another Plan which is involved in item (b) of this subsection 2. and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and
(2) the rules set forth in item (d) of this subsection 2. would require this Plan to determine its benefits before such other Plan,
then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

d. For the purposes of item (c) of this subsection 2., the rules establishing the order of benefit determination are:
(1) a Plan without a coordinating provision will always be the primary plan;
(2) the benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as a dependent;
(3) in the case of a person for whom claim is made as a dependent child:
(a) Primary of the plans covering dependent children will be determined on a "gender neutral" basis. The plan covering the dependent child of the parent whose birthdate (month and day) occurs first in the calendar year will be primary. This is called the "birthday rule".
(b) when the parents are separated or divorced and the parent with the custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody;

(c) when the parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody, and the benefits of a Plan which covers that child as a dependent of the spouse of the parent with custody will be determined before the benefits of a Plan which covers that child as a dependent of the spouse of the parent without custody.

Notwithstanding (b) and (c) above, if there is a court decree which would otherwise establish financial responsibility for the medical, or other health care expenses with respect to the child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent:

(4) when rules (1), (2), and (3) do not establish an order of benefit determination, the benefits of a Plan which has covered such person the longer period of time.

(5) the benefits of a Plan which covers a Person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that Person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.

e. When the provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

f. When a covered person incurs charges which result from accidental bodily injury, this plan will be secondary to any other insurance policies or reimbursement plans.

4. COORDINATION WITH MEDICARE

The Medicare Secondary Payer regulations provide special rules regarding the order of benefits determination for persons who are covered under Medicare. In general, these regulations provide:

a) If the active Employee (or their dependent), is age 65 or older, Medicare is secondary to Plans of Employers with at least 20 Employees.
b) If the claimant has kidney failure and is receiving dialysis, Medicare is secondary to the Plans of all Employers for the first 30 months, regardless of the number of Employees.
c) Different rules apply if you or your covered dependent becomes eligible for Medicare coverage due to a disability other than End-Stage Renal Disease (ESRD). In such case, the order of benefits determination will be based upon the current, applicable Medicare Secondary Payer regulations.

Active employees who are also Medicare beneficiaries are free to elect Medicare as their primary payer. However, if they do so there is no coverage available under this Plan. Important note: If a Medicare-eligible Employee elects Medicare as primary, no Plan coverage will be available for any of his dependents.

If active employees who are also Medicare beneficiaries elect medical coverage under this Plan, this Plan will be primary. This Plan will pay its benefits first, and then the claims may be submitted to Medicare for consideration.

B. HEALTH MAINTENANCE ORGANIZATION

If you and/or your eligible dependents while covered under this plan are also covered under an HMO (Health Maintenance Organization) provided by another employer and receive treatment through the HMO provider, no benefits will be payable for such treatment under this Plan.

For treatment received outside of the HMO setting for which you are expected to pay, benefits will be paid up to the limitations of this Plan.

If you are a member of a Health Maintenance Organization (HMO) qualified under Section 1310 of the HMO Act of 1973 sponsored by this employer and join this Plan, coverage becomes effective the day following termination of coverage under the HMO. There is no pre-existing condition restriction on you.

If you are covered by this Plan and join an HMO sponsored by this employer, coverage under this Plan terminates the day preceding membership in the HMO.

C. STATE MEDICAL ASSISTANCE PROGRAM

The Plan will not limit or exclude the benefits payable by the Plan due to a person being covered by a State Medical Assistance Program.

Benefits will be paid to the State or state agency and will be paid up to the cost of medical expenses paid by the state through medical assistance. Benefits paid to the state will not be more than the benefits to which the covered person is entitled under the Plan.

D. SUBROGATION AND RECOVERY

1. EXCLUSION OF BENEFITS AND ASSIGNMENT

Benefits are not payable for injury(ies) or illness(es) to you or your dependent to which a third party(ies) may have caused or contributed. However, the plan may elect, in its sole discretion, to advance payments for medical expenses incurred for any injury(ies) or illness(es) to you or your Dependents to which a third party(ies) may have caused or contributed. By accepting medical treatment for any injury(ies) or illness(es) to which a third party(ies) may have caused or contributed, you or your dependent assigns to the plan all his or her rights to recover from any source an amount equal to the amount advanced for you or your dependent's injury(ies) or illness(es). As assignee, the plan shall recover the first dollar you or your dependent is entitled to receive from any source for you of your dependent's injury(ies) or illness(es) up to the amount advanced, regardless of whether you or your dependent is made whole, regardless of whether you or your dependent has been paid for all of his or her claims for damages, and regardless of how the payment is described. The made whole doctrine shall not apply to the plan's right of assignment. The Plan's right of assignment is a right of first reimbursement and takes priority over any person's interest in such payment. The plan's right of assignment shall not be reduced by any attorney's fees, court costs, or other expenses incurred by you or your dependent to recover such payments. If the plan is precluded from exercising our right of assignment, the plan may exercise our right of subrogation and/or reimbursement as stated below.

2. SUBROGATION OF BENEFITS

This provision does not apply to Life Insurance Benefits, Accidental Death and Dismemberment Benefits, or benefits payable for any loss of time on account of disability, if any such benefits are provided in the Coverage.

If payments are made under this Plan for any treatment or service because of injury to, or sickness of, a covered individual who has a lawful claim, demand or right against a third party or parties (including an insurance carrier or uninsured motorist coverage) for indemnification, damages or other payment with respect to such injury or sickness, then:

a) The Plan shall be subrogated, to the extent of the payments made under this Plan, to the rights of the covered individual to receive or claim such indemnification, damages or other payment.
b) The covered individual and their legal counsel, if any, shall execute or secure the execution of such instruments as the Plan may reasonably require to enforce its rights hereunder; and
c) Any individual who shall receive payment from any such third party or parties because of injury to, or sickness of, a covered individual shall first reimburse the Plan (before reimbursing any third parties) from such payment so received (but not in excess of the amount received) for all payments made, past, present, and future under this Plan for treatment or service with respect to the same injury or sickness.
d) Such first reimbursement shall be made to the Plan, without set-off for attorney fees or any other costs or expenses and without regard to whether the covered individual has been "made whole" for his/her damages.
e) Should the covered individual fail to reimburse the Plan first from any such payment received, the Plan may file suit to recover, and the covered individual will be solely responsible for any court costs in connection with such suit.

The participant is required to submit a copy of a Subrogation Agreement provided by the Plan office which has been signed by the participant and their legal counsel, if any, as a necessary part of proof of loss for a claim involving a third party action. Failure to submit such signed agreement may cause payment of the claim to be delayed until the third party action is resolved or disallowed due to failure on the part of the participant to provide adequate proof of loss. **Under no circumstances will the Plan share in or assume liability for any legal fees or any other costs and expenses incurred by the covered individual in connection with any third party claim, and its rights of Subrogation and First Reimbursement shall not be subject to the "Make Whole" doctrine as defined under ERISA.**

3. REIMBURSEMENT

If you or your dependent recovers from any source any amount for any injury(ies) or illness(es) for which the plan advanced medical payments, you or your dependent shall reimburse the plan an amount equal to the amount advanced or the amount of you or your dependent's recovery, whichever is lesser. The plan shall recover the first dollar you or your dependent is entitled to receive from any source for you or your dependent's injury(ies) or illness(es), regardless of whether you or your dependent is made whole, regardless of whether you or your dependent has been paid for all of his or her claims for damages, and regardless of how the payment is described. The made whole doctrine shall not apply to the plan's right of reimbursement. The plan's right of reimbursement is a right of first reimbursement and takes priority over any person's interest in such payment. The plan's right of reimbursement shall not be reduced by any attorney's fees, court costs, or other expenses incurred by you or your dependent to recover such payments. If the plan is precluded from exercising our right of reimbursement, the plan may exercise our right of assignment and/or subrogation.

4. COOPERATION

You or your dependent or your legal representative must cooperate fully with the plan in asserting the plan's recovery rights under paragraphs 1- 3. You and your dependent or your legal representative shall, upon request, provide all information and sign and return all documents requested by the plan in enforcing the plan's rights under this plan. If you, your dependent and/or your counsel refuse to cooperate or pay over any funds due to the Plan under this Article, or adversely prejudice the Plan's rights by any act or omission, the Plan Administrator may, in addition to the other rights set forth herein:

a) Offset and reduce any future benefits that may be payable to you or any of your covered dependents, whether or not related to the incident giving rise to the Plan's right of subrogation and/or reimbursement, to the extent of the Plan's right of recovery; and/or
b) Terminate participation of you and your dependents, if any, under the Plan on a date established by the Plan Administrator, without any further rights to benefits hereunder. In the event of the termination of your and your dependent's participation under the Plan, it shall not constitute a COBRA qualifying event.

5. LIABILITY AND ATTORNEY'S FEES

If you or your dependent or your legal representative fails to cooperate with the plan in enforcing our rights under this plan or recovers from any source any amount for any injury(ies) or illness(es) for which the plan advanced medical payments and fails to immediately reimburse the plan for the total amount advanced, you or your Dependent and your legal representative shall be jointly and severally liable to the plan in an amount equal to the amount advanced plus reasonable attorney's fees and court cost incurred by the plan in enforcing our rights under this plan. These rights are in addition to any rights the plan may have against any other party(ies).

V. GENERAL PROVISIONS

A. THE PLAN

1. **PLAN CONSTRUCTION**. This Plan shall be construed in accordance with ERISA. The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. Section titles are for convenience of reference only and are not to be considered in interpreting this Plan.

2. **CONFORMITY WITH LAW**. Notwithstanding any other provision to the contrary, this Plan Document is held to be in compliance with P.L. 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), with P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1995 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and with any applicable regulations. If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

3. **PLAN IS NOT A CONTRACT**. This Plan shall not be construed as a contract, consideration, or inducement of employment, or as affecting in any manner or to any extent whatsoever the rights or obligations of the Employer or any Employee to continue or terminate employment at any time.

4. **PLAN DESCRIPTION**. The Planholder shall provide to Employees who are Covered Persons a Summary Plan Description containing the benefits of this Plan and the rights and obligations of Covered Persons under this Plan.

5. **CHANGES TO PLAN**. This Plan may be changed by the execution of an amendment to this Plan by the Planholder at any time without prior notice to or the consent of any Covered Person or of any person entitled to receive payment of benefits under the Plan. The Planholder shall provide to the covered Employees a summary of any material change to this Plan within 60 days of such change.

6. **TERMINATION OF PLAN**. The Planholder may terminate this Plan at any time by providing written notice to the Covered Employees. Such termination will become effective on the date set forth in such notice.

7. **WRITTEN NOTICE**. Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

8. **WAIVER**. The failure of the Planholder to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Planholder reserves the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Planholder and regardless of the similarity of the circumstances or the number of prior occurrences.

9. **CLERICAL ERROR/DELAY**. Clerical errors made on the records of the Planholder and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

10. **WORKER'S COMPENSATION**. This Plan does not replace, nor does it affect, any requirement for coverage by worker's compensation insurance.

B. MISSTATEMENTS ON APPLICATION

If any relevant fact has been misstated by or on behalf of any person to obtain coverage under this Plan, the true facts shall be used to determine whether coverage is in force and the extent, if any, of such coverage. Upon the discovery of any such misstatement and consequent termination of coverage, an equitable adjustment of any contributions will be made.

C. LEGAL PROCEEDING

Legal action to recover any lost benefits under this Plan may not be brought prior to the expiration of 180 days after Proof of Loss has been filed in accordance with the requirements of the Plan nor until the Plan's appeal procedure, including utilization of a professional/peer review committee, has been exhausted per the terms of ERISA, and not later than two (2) years after the final claim denial. See also “Claims Review and Appeal Procedures.” If you fail to timely appeal, you cannot bring a lawsuit because you did not exhaust your administrative appeal rights.

D. PHYSICAL EXAMINATION

The Administrator, at its own expense, will have the right and opportunity, while claim is pending, to examine any individual on whose behalf claim is made, as often as it may reasonably require. It also has the right to make an autopsy when not forbidden by law.

E. PHYSICIAN-PATIENT RELATIONSHIP

Any person covered under this Plan will have free choice of any Physician practicing legally. The Plan Administrator will in no way disturb the physician-patient relationship.

F. BASIS ON WHICH PAYMENTS ARE BEING MADE FROM THE PLAN

The Plan Administrator shall from time to time evaluate the costs of Plan and determine the amount to be contributed by the Plan Administrator and the amount to be contributed (if any) by each covered participant. Payments from the Plan shall be made first from any such contributions. The employer pays Plan benefits and administration expenses directly from general assets.

G. FUNDING POLICY

Not withstanding any other provision of the Plan, the Plan Administrator’s obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph entitled "Basis on Which Payments are Being Made from the Plan".

In the event that the Plan Administrator terminates the Plan, then as of the effective date of termination, the Plan Administrator (and covered employee and dependent participants) shall have no further obligation to make additional contributions to the Plan. In addition, coverage for allowable claims filed after such Plan termination date shall be limited to those remaining assets of the Plan (if any).

If there are not sufficient assets in the Plan to provide the benefits otherwise payable under the Plan, then such benefits shall not be payable under the Plan and neither the Plan Administrator, Administrative Manager, Trustee nor the Plan Supervisor shall be liable for such benefits.

H. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this plan or any provision of similar purpose of any other Plan, the Plan Administrator may, without the consent or notice to any person, release to or obtain from any insurance company or other organization or individual any information, with respect to any person, which the Plan Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

I. FACILITY OF PAYMENT

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

J. RIGHT OF RECOVERY

Whenever any payment for Covered Expenses has been made by this Plan in an amount which exceeds the maximum benefits available under the provisions of this Plan, or when payment has been made in error by the Plan for non-covered expenses, the Plan will have the right to recover such excess or erroneous payment from one or more of the following, as the Plan Administrator shall determine: Any persons to or for or with respect to whom such payment was made, any insurance companies, or any other organizations. As an alternative, the Plan reserves the right to deduct from any pending claim for payment any amounts the Covered Person owes the Plan.

K. MEDIUM OF PAYMENT

All payments made by or to this Plan in connection with the benefits of Covered Persons shall be made in lawful money of the United States, which, at the time of payment, is legal tender for public and private debts.

VI. ELIGIBILITY

A. EMPLOYEES REQUIREMENTS

The following individuals are eligible for coverage under the plan:

1. Class I, consisting of driver employees who are regularly scheduled to work at least 30 hours per week in the employ of the employer (herein called employees within the eligible classes);
2. Class II, consisting of hourly and salary employees who are regularly scheduled to work at least 30 hours per week in the employ of the employer (herein called employees within the eligible classes); and
3. dependents of those employees who are meeting the requirements of 1. and 2. above.

Eligible employees will not include temporary employees, seasonal employees, part-time employees, retired employees, and their dependents.

Each employee must complete and sign an enrollment form that the Plan administrator has approved within 30 days of their initial eligibility date.

No coverage is provided for Late Enrollees (individuals who do not enroll within 30 days of their Initial Eligibility Date). A Special Enrollee, as described in section E, shall not be considered a Late Enrollee.

B. EFFECTIVE DATE – EMPLOYEES

For all eligible employees, coverage will begin on the Initial Eligibility Date, which is the date of hire.

If an employee qualifies for coverage without being subject to the Waiting Period, such as following a lay-off or leave lasting longer than 63 days, he may be subject to the Pre-existing Conditions provision, unless he is recalled during a period in which the employer is paying his premium, or he continues coverage by direct payment of COBRA premiums without a break in coverage of at least 63 days.

C. DEPENDENT ELIGIBILITY

1. Eligible Dependents of an Employee are:

   a. A legal spouse of the opposite sex. Such spouse must meet all requirements of a valid marriage contract in the state of residence but will not include a common law spouse and must be a resident of the same country in which the participant resides; and
   b. unmarried children who are under nineteen (19) years of age and who are not employed on a full time basis. "Children" include:
      - an Employee's natural children who are dependent on the employee for principal support,
      - step children,
      - foster children and any other children who are dependent upon you and residing with you in a regular parent-child relationship or who legally qualify to be claimed as a dependent on your federal income tax return,
      - legally adopted children and children under the age of eighteen (18) who have been placed with the employee and for whom the employee has accepted financial responsibility for the purpose of adoption,

- a child for whom the Employee or covered spouse is required to provide coverage due to a Qualified Medical Child Support Order (QMCSO) which is determined solely by the Plan Administrator and in accordance with its written procedures (which are incorporated herein by reference).

c. unmarried children who are age 19 but less than 24 who, except for age, meet the requirements of b. above and who are regularly attending an accredited school or college on a full time basis. (Full time means the equivalent of 12 credit hours per semester.) Cessation of full time school attendance will terminate a child's eligible dependent status; except, if cessation is due to school vacation and the student is enrolled for the following semester, eligible dependent status will terminate on the date the school reconvenes if attendance does not resume. You should submit proof of full-time student status prior to the nineteenth (19th) birthday, and you must notify the Plan of any change in status.

   If an unmarried child is (on the date such child's coverage would otherwise terminate due to age) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and such incapacity commenced prior to the date such child's coverage would otherwise terminate, and such child is chiefly dependent upon the Employee for support and maintenance, the Plan will, upon payment of the applicable premium, continue coverage for such unmarried child so long as such Employee's coverage remains in force and such incapacity continues; provided proof of such incapacity is submitted to the Plan within 30 days of the date dependent coverage would otherwise have terminated.

2. If both husband and wife are covered under the Plan as Employees, either, but not both, may elect to cover children eligible as described above. Children are never eligible to be covered by two (or more) entities under the same plan.

3. Benefits payable on behalf of a Dependent previously covered under the Plan as an Employee for hospital, surgical and medical expenses incurred during a period which began while the Dependent was covered as an Employee shall not exceed the benefits that would have been payable during such period had the Dependent remained covered as an Employee. This provision also applies to Employees previously covered under the Plan as a Dependent.

D. EFFECTIVE DATE – DEPENDENTS

Coverage for eligible dependents who are enrolled concurrently with the Employee will begin on the Employee's effective date. Coverage for eligible dependents who are acquired after the Employee's effective date will begin as follows:

1. Newborn or newly adopted children will be covered from the moment of birth or placement for adoption for Injury or Illness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled within thirty (30) days of the child's date of birth or placement for adoption. This provision shall not apply to or in any way affect the normal maternity provisions applicable to the mother.

2. A Spouse will be considered an eligible Dependent from the date of marriage, provided the Spouse is properly enrolled within thirty (30) days of the date of marriage.

3. If a Dependent is acquired other than at the time of his birth, due to a court order, decree, or marriage, that Dependent will be considered an eligible Dependent from the date of such court order, decree, or marriage provided that this new Dependent is properly enrolled within thirty (30) days of the court order, decree, or marriage.

4. A child may become eligible as set forth in a qualified medical child support order (QMCSO). The Plan Administrator will establish written procedures for determining (and shall have sole discretion to determine) whether a medical child support order is qualified and for administering the provision of benefits under the Plan pursuant to a qualified medical child support order.

   The Plan Administrator may seek clarification and modification of the order, up to and including the right to seek a hearing before the court or agency which issued the order. Such children may remain covered for the duration of the QMCSO or until proof is provided of comparable coverage, subject to the provisions of the Plan.

E. INCREASE IN AMOUNT OF COVERAGE

An increase in the amount of a covered person's coverage by reason of change in classification or change in the amount of benefits payable under the Plan shall become effective on the first day of the month coinciding with or next following the effective date of such change; however, if an individual is not actively at work or if an injury or sickness disables and prevents a dependent from performing the duties of his regular occupation or engaging in the normal activities of a person of like age and sex in good health when an increase in the amount of his coverage would otherwise take effect, it shall take effect on the first day of the month next following the date the individual is actively at work or the dependents' disability ends, provided the person still meets the eligibility requirements.

F. SPECIAL ENROLLEES

1. An eligible employee who experiences a family status change through marriage, birth, adoption, or placement for adoption, or an eligible employee who originally declined coverage under this Plan due to other health coverage and who has had continuous coverage since that date, will be considered a Special Enrollee eligible for coverage, provided the request for coverage is received within thirty (30) days of the family status change or the loss of the other health coverage. “Loss of coverage” shall mean loss as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or exhaustion of COBRA coverage. “Loss of coverage” does not include loss due to failure to pay premiums on a timely basis, a voluntary election to terminate such coverage, or termination of coverage for cause (such as making a fraudulent claim). Coverage will then be effective on the date of such change or loss.

2. If a Dependent originally declined coverage due to other health coverage and has had continuous coverage since that date, that Dependent will be considered a Special Enrollee eligible for coverage, provided the request for coverage is received within thirty (30) days of the termination of that coverage and the loss of coverage is a qualified loss under the plan. Coverage will then be effective on the date of such change or loss.

3. **No coverage is provided for Late Enrollees.** If application for coverage is not made within 30 days of the Initial Eligibility Date, the individual shall not be eligible to enroll in the Plan except as a Special Enrollee described above.

G. REINSTATEMENT/REHIRE

If an employee returns to active employment and eligible status following an approved leave of absence in accordance with the employer's guidelines and the Family and Medical Leave Act (FMLA), and during the leave the employee discontinued paying his share of the cost of coverage causing coverage to terminate, such employee may have coverage reinstated (for himself and any dependents who were covered at the point contributions ceased). However, Employee must request that coverage be restored before his family or medical leave expires. No waiting period requirement will be applied and the preexisting condition limitation will apply only to the extent it may have applied on the date coverage terminated.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain employees who return to active employment following active duty service as a member of the United States armed forces, will be reinstated to coverage under the Plan immediately upon returning from military service.

H. EMPLOYEE CONTRIBUTIONS

Your coverage is contributory. Your dependent's coverage is also contributory. Contributions are based on affirmations of the employee. Fraudulent affirmations may result in denial of claims in whole or in part as determined by the Plan Administrator.

VII. TERMINATION OF BENEFITS

A. TERMINATION FOR EMPLOYEE

Employee benefits will cease on the earliest of:

1. the date his membership in an eligible class ceases;
2. the date his employment with the Employer ceases;
3. the date he or the Employer cease to make the required contribution for his benefits;
4. the date the Plan ceases; or
5. the date he is pensioned or retired.

B. TERMINATION FOR DEPENDENT

Dependent benefits will cease on the earliest of:

1. the date the employee is transferred to a class of employees not covered by benefits;
2. the date the employee ceases to have a covered dependent
3. the date the employee's benefits ceases; or
4. the date we cancel all dependent benefits under the Plan.

Coverage providing benefits for medical care expenses may be continued for a Dependent who is mentally or physically incapable of earning a living and who is dependent upon you for support and maintenance provided you furnish evidence of the Dependent's incapacity within 30 days after the Dependent reaches the limiting age.

Any coverage continued for such a Dependent child will terminate under any of the conditions described above, or, in any event, when the Dependent ceases to be incapacitated, or at the end of the 30 day period after any requested proof of continued incapacity is not furnished.

C. MATERIAL MISREPRESENTATIONS:

Benefits may be denied or coverage terminated if:

1. It is found that a Covered Person's application contains material misrepresentations designed to cause the Plan to issue the coverage when it would not have ordinarily done so; or,
2. If any claim submitted by the Covered Person contains material misrepresentations designed to cause the Plan to pay benefits in excess of any benefits which would have been otherwise provided.

In the event coverage is terminated due to either of the above, the date of termination will be the Covered Person's original effective date or the date of the claim submission, respectively.

VIII. SPECIAL PROVISIONS

A. INFORMATION OF INTEREST AS REQUIRED BY...ERISA

1. ERISA

You most likely have heard about ERISA. ERISA stands for the Employee Retirement Income Security Act which was signed into law in 1974.

This federal law established certain minimum standards for the operation of employee benefit plans including the Star Transportation, Inc. Employee Benefit Plan. The Owner of your Plan, in consultation with their professional advisors, have reviewed these standards carefully and have taken whatever steps are necessary to assure full compliance with ERISA.

ERISA requires that plan participants and beneficiaries be provided with certain information about their benefits, how they may qualify for benefits, and the procedures to follow when filing a claim for benefits. This information is presented for you in this booklet.

ERISA also requires that participants and beneficiaries be furnished with certain information about the operation of the plan and about their rights under the plan. This information follows:

a. **Name of This Plan -** The legal and common name of this plan is STAR TRANSPORTATION, INC. EMPLOYEE BENEFIT PLAN.

b. **Type of Plan -** This is a self-funded group health plan maintained by the employer providing comprehensive medical and vision expense benefits. (Life Insurance is provided by a fully insured plan.) For specific coverage see the Schedule of Benefits outlined in this booklet.

c. **Fiscal Year:** The accounting records of this plan are kept on the basis of a fiscal year which ends on December 31st each year.

d. **Name and address of Plan Administrator and Named Fiduciary as Defined by ERISA.** Your plan is maintained by Star Transportation, Inc. Any communication with the Plan should be addressed to the Plan Office at:

Star Transportation, Inc. Employee Benefit Plan
P. O. Box 100925
Nashville, TN 37224

e. **Plan Administrator Authority and Discretion** - The Plan Administrator shall have the authority to administer the Plan by its provisions and to decide all questions arising thereunder. This authority specifically includes, but is not limited to: (1) the discretion to interpret all provisions of the Plan, including eligibility provisions; (2) the discretion to apply all provisions of the Plan, including eligibility provisions; (3) the discretion to make factual determinations in respect to whether a claim is covered by the Plan; (4) the discretion to determine the type of benefits payable for a claim that has been determined to be payable; (5) the discretion to make all decisions regarding management of Plan assets.

All determinations made by the Plan Administrator are final, conclusive and binding.

2. TYPE OF ADMINISTRATION

Although the Owner is legally designated as the Plan Administrator, he has delegated the performance of the day-to-day administrative duties to a professional Administrative Manager, North America Administrators, L.P.

The Plan Office staff, maintained by North America Administrators, L.P. keeps the eligibility records, accounts for employer contributions, processes claims, informs participants of Plan changes, and performs other routine administrative functions in accordance with Plan decisions.

3. AGENT FOR SERVICE OF LEGAL PROCESS

Every effort will be made by the Plan to resolve any disagreements with participants promptly and equitably. It is recognized, however, that on a few occasions, some participants may feel that it is necessary for them to take legal action. The following is the Agent for service of legal process: **Star Transportation, Inc., P.O. Box 100925, Nashville, TN 37224**

4. PLAN IDENTIFICATION NUMBERS

When filing various reports with the Department of Labor and Internal Revenue Service, certain numbers are used to properly identify Star Transportation, Inc. Employee Benefit Plan including:

Employer Identification Number (EIN), assigned by the Internal Revenue Service... 62-1094613
Plan Number..501

5. ERISA RIGHTS NOTIFICATION

As a Participant in the Company's Group Health Program (not including any short term disability program or the dependent care program), you are entitled to certain rights and protections under ERISA.

The following lengthy statement concerning rights of Participants under ERISA is required by regulations issued by the U.S. Department of Labor. ERISA provides that all Plan Participants are entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain copies of all Plan documents governing the operation of the Plan, including the latest annual report (Form 5500 series), updated summary plan descriptions, insurance contracts and collective bargaining agreements and other information upon written request to the Company. The Company may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each member with a copy of this summary annual report.

Continue health care coverage for yourself, your Spouse, and Dependent Children if there is a Loss of Coverage as a result of a qualifying event. You or your Covered Dependents may have to pay for that coverage. Review this document and documents governing the Plan for more information about the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your Enrollment Date in your coverage.

In addition to creating rights for Plan Participants, ERISA imposes duties on the people responsible for the operation of the Plan. These people, called "fiduciaries," have a duty to operate the Plan prudently and in the interest of you and other Plan Participants and beneficiaries. Neither Company Name nor any other person may terminate your employment or discriminate against you to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored in whole or in part, you have the right to know why this was done, to obtain copies of all documents relating to the decision without charge, and to appeal any denial, all within certain time limits.

Under ERISA, there are steps that you can take to enforce the rights described above. For example, if you request materials from the Plan that the Plan is required to provide and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day (as adjusted from time to time for changes in the cost of living) until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control. If you have a claim for a Plan benefit that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan Administrator's decision concerning the qualified status of a medical child support order, or if the Plan Administrator fails to make a determination as to the qualified status of the order, you may file suit in a federal court.

If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

If you have any questions about the Plan, you should contact the Company Benefits Information Center or your Human Resources representative. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

B. CONTINUATION OF COVERAGE

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This provision contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. The Plan Administer has contracted with North America Administrators, L.P., 1212 Eighth Avenue South, P. O. Box 1984, Nashville, TN 37202, 615-256-3561, to conduct the day-to-day COBRA continuation coverage operations of the Plan (North America Administrators, L.P. is not the Plan Administrator or a fiduciary of the Plan).

1. CONTINUATION OF COVERAGE PROVISION

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event”. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” The employee, spouse, and dependent children could become qualified beneficiaries if coverage under the Plan is lost due to a qualifying event. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights as any other participant or beneficiary covered under the Plan.

Employees will become a qualified beneficiary if coverage is lost under the Plan due to either of the following qualifying events:

a) Termination of employment (except for termination due to gross misconduct); or
b) Reduction in hours of employment.

The spouse of an employee, will become a qualified beneficiary if coverage is lost under the Plan due to any of the following qualifying events:

a) Employee dies;
b) Employee’s hours of employment are reduced;
c) Employee’s employment ends for any reason other than gross misconduct;
d) Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
e) Divorce or legal separation. Also, if the employee reduces or eliminates spouse’s group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for the spouse even though coverage was reduced or eliminated before the divorce or legal separation.

A dependent child of an employee, will become a qualified beneficiary if coverage is lost under the Plan due to any of the following qualifying events:

a) Employee dies;
b) Employee’s hours of employment are reduced;
c) Employee’s employment ends for any reason other than gross misconduct;
d) Employee becomes divorced or legally separated;
e) Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
f) Child is no longer eligible for coverage under the Plan as a dependent child.

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The child’s COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements.

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the covered employee’s period of employment with the employer is entitled to the same rights under COBRA as a dependent child of the covered employee, regardless of whether that child would otherwise be considered a dependent.

2. FAMILY MEDICAL LEAVE

If an employee takes Family Medical Leave (FMLA) and does not return to work at the end of the leave, the employee (and employee's spouse and dependent children, if any) will be entitled to elect COBRA if they were covered under the Plan on the day before the FMLA leave began or became covered during the FMLA leave, or they will lose coverage within 18 months because of the employee's failure to return to work at the end of the leave. COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave.

3. FEDERAL TRADE ADJUSTMENT ASSISTANCE

Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members during a special second election period. This special second election period lasts for 60 days or less. It is the 60 day period beginning on the first day of the month in which an eligible employee or former employee becomes eligible for TAA or ATAA, but only if the election is made within 6 months immediately after the individual's group health plan coverage ended. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282.
More information is also available at www.doleta.gov/tradeact/2002act_index.asp.

4. NOTICE REGARDING QUALIFYING EVENTS

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Third Party Administrator has been notified that a qualifying event has occurred. It will be the responsibility of the Employer to notify the Third Party Administrator within 30 days after an employees' death, termination, reduction in work hours, eligibility for Medicare (it is the employee's responsibility to notify the employer).

The eligible beneficiary or covered employee must notify the Plan Administrator (Star Transportation, Inc., P. O. Box 100925, Nashville, TN 37224, 615-256-4336) in writing within 60 days after a spouse is separated or divorced or a dependent child ceases to be eligible on the basis of attained age or loss of dependent status, or within 60 days in which the qualified beneficiary loses coverage under the terms of the Plan as a result of the qualifying event. Any notice provided must be in writing. Oral notice, including notice by telephone, is not acceptable. If mailed, notice must be postmarked no later than the last day of the required notice period. Any notice provided must state the name of the Plan, the name and address of the employee covered under the Plan, and the name(s) and address (es) of the qualified beneficiary (ies). Notice must also name the qualifying event and the date it happened and include the applicable copy of the social security determination for disability, divorce decree, or child's birth certificate. Notice of a second qualifying event also must name the event and the date it happened.

5. DURATION OF CONTINUATION

Once the Third Party Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. The beneficiary will have 60 days following the date notice of continuation right is sent by the Plan Administrator, or the date of the qualifying event, whichever is later, to elect COBRA continuation coverage.

When the qualifying event is the death of the employee, enrollment of the employee in Medicare, divorce or legal separation, or a cessation of eligibility on the part of a covered dependent as defined under the terms in the Plan, COBRA continuation coverage can last for up to 36 months.

When the qualifying event is termination of employment or reduction in hours, coverage may be continued for up to 18 months. These 18 months may be extended for the spouse and dependent children to a maximum of 36 months from the date employment was terminated or hours reduced if a second qualifying event (such as a death, divorce, legal separation, or Medicare entitlement) occur during that 18-month period. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. However, the Plan Administrator (Star Transportation, Inc., P. O. Box 100925, Nashville, TN 37224, 615-256-4336) must be notified in writing of the second qualifying event within 60 days of the second qualifying event, or 60 days from the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event.

If an employee, spouse, or dependent child who is covered under the Plan is disabled before or during the first 60 days of COBRA, and is subsequently determined to be disabled under the Social Security Act before the end of the 18 month period of COBRA, and you notify the Plan Administrator in writing within 60 days of the date of the determination or within 60 days of the date of the employee's termination or reduction of hours, or the date on which the qualified beneficiary loses coverage under the terms of the Plan as a result of the covered employee's termination or reduction in hours, the maximum period of coverage continuation may be extended an additional 11 months (to a maximum COBRA coverage period of 29 months). This extension is available only for qualified beneficiaries who are receiving COBRA coverage due to the qualifying event being the covered employee's termination of employment or reduction in hours.

6. COST OF CONTINUED COVERAGE

In the event continuation is elected, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. The qualified beneficiary must make payment of the initial contribution within 45 days of the date of the election.

Those individuals electing continuation of coverage must pay a contribution which will be 102% of cost of the Plan. (For the 11 month extension for a total disability, the contribution will be increased to 150% of the cost of the Plan.)

Payment of the required contribution will be due on a monthly basis and must be postmarked by the 30th day of the month for which it is due to be considered timely. **LATE PAYMENTS WILL NOT BE ACCEPTED AND RESULT IN TERMINATION OF COVERAGE.** No notices will be sent and it will be the sole responsibility of the individual to make timely payment of contributions. Payments must be sent to the address indicated on the election notice provided at the time of the qualified event.

7. TERMINATION OF CONTINUED COVERAGE

Continuation coverage will be terminated before the end of the maximum period if:

a) any required premium is not paid in full on time;
b) a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan but only after any pre-existing condition exclusion of that other Plan for a pre-existing condition of the qualified beneficiary has been exhausted or satisfied;
c) a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or;

d) the employer ceases to provide any group health plan for its employees; or
e) during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled.
f) if coverage is modified or terminated for similarly situated employees, COBRA coverage will be modified or terminated in the same manner.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

The Plan Administrator must be notified within 30 days of, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or is determined to no longer be disabled.

8. ADDITIONAL INFORMATION

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

If you have any questions about your COBRA continuation coverage, you should contact North America Administrators L.P., or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

C. FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

Regardless of the Employer's established leave of absence policies, this Plan will at all times comply with the regulations of the Family and Medical Leave Act of 1993 as set forth by the Department of Labor.

If an Employee does not return to work from FMLA leave, Coverage under this Plan will terminate unless election is made to continue Coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The Plan has the right to recover premiums paid for the leave period for any employee who fails to return to work.

This provision permits the Plan Administrator to receive Protected Health Information in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.

D. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act ("Newborns' Act") includes important protections for mothers and their newborn children with regard to the length of the Hospital stay following childbirth. The Newborns' Act requires that group health plans that offer maternity coverage pay for at least a 48-hour Hospital stay following childbirth (96-hour stay in the case of Cesarean section).

E. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act (WHCRA) requires all group health plans and health issuers that already offer benefits for a mastectomy, to also provide coverage for the ensuing breast reconstructive surgery. Plans also have to cover surgery on the nonaffected breast to ensure a symmetrical appearance. The WHCRA also mandates coverage for prostheses and for all other services used to treat physical complications during all stages of a mastectomy, including lymphedemas.

In addition, the WHCRA prohibits group health plans and health insurance issuers from denying renewal or initial enrollment to an individual in order to avoid providing the mandated benefits. Finally, health plans may not use financial incentives (monetary or otherwise) in order to discourage attending health Providers from performing the medical services described in the WHCRA.

The Plan is required to provide Participants with an annual notice about these coverage standards upon enrollment and annually thereafter. Specifically, WHCRA requires that the Plan provide the following benefits coverage:

1. Reconstructive surgery after a mastectomy;
2. Surgery on the nonaffected breast to ensure a symmetrical appearance;
3. Prostheses; and
4. Other physical complications stemming from a mastectomy, including lymphedemas.

In accordance with WHCRA, the Plan provides the Participant with the above coverages. Please note that such coverage is subject to all other provisions of the Plan, including any Deductible Amount and/or coinsurance provisions under the Plan.

F. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") – PRIVACY RULES

1. THE FOLLOWING DEFINITIONS APPLY FOR PURPOSES OF THIS PROVISION:

a) **"Health Maintenance Organization"** is defined as it is in 45 C.F.R. 160.103, or any successor thereto.
b) **"Health Insurance Issuer"** is defined as it is in 45 C.F.R. 160.103, or any successor thereof.
c) **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.
d) **"Protected Health Information"** is defined as it is in 45 C.F.R. 164.501, or any successor thereto.

2. PLAN ADMINISTRATOR'S CERTIFICATION OF COMPLIANCE

Prior to receiving any Protected Health Information, the Plan Administrator will certify that this provision has been incorporated into the Plan documents and that the Plan Administrator agrees to abide by the provisions herein. Neither the Plan, a Health Care Maintenance Organization, nor a Health Insurance Issuer will disclose Protected Health Information to the Plan Administrator until the Plan Administrator has provided the certification, as required by HIPAA.

3. PERMITTED USES AND DISCLOSURES

The Plan Administrator may use or disclose Protected Health Information to carry out Plan administration functions consistent with the requirements of HIPAA. Any disclosure to and use by the Plan Administrator of Protected Health Information will be subject to and consistent with the provisions herein. The Plan Administrator may use and disclose Protected Health Information to the extent necessary to comply with its obligations under HIPAA.

4. RESPONSIBILITIES AND UNDERTAKINGS

a) The Plan Administrator will not use or further disclose protected Health Information, except as permitted or required by the Plan documents, as amended, or as required by law.
b) The Plan Administrator will ensure that any agent, including any subcontractor to whom it provides Protected Health Information agrees to the same conditions and restrictions that apply to the Plan Administrator.
c) The Plan Administrator will not use or disclose Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Administrator.
d) The Plan Administrator will report to the Plan any use or disclosure to Protected Health Information that is inconsistent with the uses and disclosures allowed under this provision promptly upon learning of the inconsistent use or disclosure.
e) The Plan Administrator will make Protected Health Information available to the individual who is the subject of the information in accordance with 45 Code of Federal Regulations 164.524.
f) The Plan Administrator will make an individual's Protected Health Information available for amendment, and will incorporate any amendments to the individual's Protected Health Information, in accordance with 45 Code of Federal Regulations 164.526.
g) The Plan Administrator will keep track of disclosures it may make of Protected Health Information so that it can make available the information required for the Group Health Plan to provide an accounting of disclosure in accordance with 45 Code of Federal Regulations 164.528.
h) The Plan Administrator will make its internal practices, books, and records, relating to its use and disclosure of Protected Health Information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with 45 Code of Federal Regulations Parts 160-64.
i) If feasible, the Plan Administrator will return or destroy all Protected Health Information, in any form, received from the Plan, and the Plan Administrator will not retain copies of the information after the information is no longer needed for the purpose for which the disclosure was made. If returning or destroying the information is not feasible, the Plan Administrator will limit the use or disclosure of the information to those purposes that make the return or destruction infeasible.
j) The Plan Administrator further agrees that if it creates, receives, maintains, or transmits any electronic protected health information, other than enrollment/disenrollment information and summary health information, it will comply with the HIPAA security regulations, effective as of the date set forth in the regulations, on behalf of the covered entity, and it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information, and it will ensure that any agents, including subcontractors, to whom it provides such electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information. The Plan Administrator will report to the Plan any security incident of which it becomes aware.

5. ADEQUATE SEPARATION BETWEEN THE PLAN SPONSOR AND THE GROUP HEALTH PLAN.

a) The Plan Administrator shall insure that the adequate separation between the group health plan and the Plan Administrator is established.
b) All employees, classes of employees, or other workforce members as designated by the terms of the plan document, who have access to Protected Health Information, have been trained to appropriately handle Protected Health Information in accordance with the HIPAA privacy rules.
c) The employees, classes of employees or other workforce members identified in the plan document, will have access to Protected Health Information only to perform the Plan's administration functions that the Plan Sponsor provides for the Plan.
d) The employees, classes of employees or other workforce members identified in the plan document, will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Administrator for any use or disclosure of Protected Health Information that violates the provisions herein. The Plan Administrator will promptly report any violation to the Plan, as required by this provision. The Plan Administrator will also cooperate with the Plan to correct the violation, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the violation, and to mitigate any deleterious effect of the violation on the individual whose privacy rights may have been compromised by the violation.
e) The Plan Administrator will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic protected health information.

IX. DEFINITIONS

To understand the benefits provided for you and your Dependents, it is necessary to know the following terms:

Accidental Bodily Injury or Injury - A bodily injury sustained accidentally and independently of all other causes by an outside traumatic event or due to exposure to the elements that is: unforeseen, unexpected, involuntary and due to violent and external means. The terms "accidental bodily injury" and "injury" do not include injury which arises out of or in the course of any employment or occupation for compensation or profit. Only charges incurred within 90 days from the date of loss will be covered as an accident. Charges incurred after 90 days from the date of loss will be covered as an illness.

Actively at Work - On a specified day, an Employee is not absent from work.

Annual - Calendar Year (January 1 - December 31)

Average Semi Private Rate – The most common rate for a semi private room. If the hospital is an all private room hospital, the average semi private rate will be deemed to be the prevailing private room rate.

Benefits Payable - When you incur Covered Expenses for yourself or on behalf of a Dependent for care of Injury or Illness, while covered under the Plan, you will become entitled to comprehensive medical benefits, subject to the Deductible Amount as provided in the Schedule of Benefits.

Certificate of Creditable Coverage – The certification of coverage that must be provided to the Covered Person when coverage under a Plan ceases. The certification must be provided automatically within a reasonable time period after coverage ceases and in the twenty-four (24) month period after coverage ceases, upon request.

Chemical Dependency - A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) criteria.

Child - Any Participant up to 19 years of age who otherwise meets the definition of dependent under the Plan.

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

COBRA Continuee - A person who is receiving continuation of coverage (within the meaning of Section 4980B of the Code) under a group health care plan maintained by the Company. A person shall cease to be a COBRA Continuee on the date that the "maximum required period" (as defined in Section 4980B of the Code) ends for the "qualifying event" (as defined in Section 4980B of the Code) giving rise to his continuation coverage or if earlier, when COBRA coverage terminates hereunder.

Code - The Internal Revenue Code of 1986, as amended from time to time.

Company – the Employer maintaining this Plan of benefits.

Covered Person - An eligible Employee or eligible Dependent who is covered under this Plan.

Creditable Coverage - This term is defined in ERISA Section 701 (c). Under this provision, Creditable Coverage generally includes periods of coverage under an individual or group health plan (including Medicare, Medicaid, governmental and church plans) that are not followed by a 63 day break in coverage. Creditable Coverage does not include coverage for liability, dental, vision, specified disease and/or other supplemental-type benefits. Waiting periods and HMO affiliation periods are not considered a break in coverage.

Custodial Care - "Custodial Care" shall mean services, including room and board, or supplies provided to a person:

1. Who is not receiving medical treatment for rehabilitation from an injury or illness; or
2. For the purpose of assisting the person in the activities of daily living; and
3. When such services or supplies do not require the continuous attention of trained medical personnel.

Custodial Care includes but is not limited to: administration of medicines, dressings or therapies which can be self-administered; routine monitoring of vital signs; help in walking, getting in and out of bed, bathing, dressing and eating.

Deductible - The amount of the deductible as it applies to Covered Expenses is shown in the Schedule of Benefits. The Deductible Amount applies separately to each member of your family once during each calendar year (except as provided under "Family Limit" below) even though expenses may be incurred for several Illnesses or accidents during the year.

- **Family Limit** - Normally, the Deductible Amount applies separately to each member of the family. However, after you have satisfied the Family limit indicated in the Schedule of Benefits, Covered Expenses incurred by you or on behalf of any other members of your family during the remainder of the calendar year will not be subject to Deductible Amounts.

Durable Medical Equipment - Equipment which (a) can withstand repeated use, (b) can only be used to serve the medical purpose for which it is prescribed, (c) generally is not useful to a person in the absence of an illness or accidental bodily injury, and (d) is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be DURABLE MEDICAL EQUIPMENT. Such equipment will not be considered a covered service simply because its use has an incidental health benefit.

Employee – One who provides services for wages or salary and receives a W-2 from the Employer.

Employer – One who engages the services of others for wages or salary.

Enrollment Date - The first day of coverage under this Plan (see Eligibility Requirements) or, if earlier, the beginning of any applicable Waiting Period hereunder.

ERISA - The Employee Retirement Income Security Act of 1974 as amended.

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

a) Is not accepted as standard medical treatment for the Illness, disease or injury being treated by Physicians practicing the suitable medical specialty; or
b) Is the subject of scientific or medical research or study to determine the item's effectiveness and safety; or

c) Has not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including without limitation, the Federal Department of Health and Human Services Food and Drug Administration, or any comparable state governmental agency, and The Federal Health Care Finance Administration as approved for reimbursement under Medicare Title XVIII; or
d) Is performed subject to the Covered Person's informed consent under treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.

In determining whether a treatment, equipment, technology, drug, procedure, or supply is Experimental, the view of the state or national medical communities shall be considered as well as whether:
a) Scientific evidence permits conclusions concerning the effect of health outcome;
a) The net health outcome for the patient is improved, as much or more than established alternatives; and
b) Improvement in the patient's condition would be attainable through the use of more conventional or widely recognized treatment alternatives.

Treatment may be considered Experimental within this definition, even if a Physician has previously prescribed, performed, ordered, recommended, or approved such treatment. Charges for Experimental or Investigational treatment, equipment, new technology, drug, procedure, service, or supply are excluded from coverage.

Formulary: Formulary drugs are a list of prescription drugs that have been selected and approved by the Pharmacy and Therapeutics committee for their safety, quality, and cost effectiveness.

Generic: Medications that have the same active ingredients, and provide the same clinical benefits, as their brand-name counterparts. Generic equivalents become available when a brand-name drug patent expires.

Hospital - An institution which meets fully every one of the following tests:
1. it provides medical and surgical* facilities for the treatment and care of injured or sick persons on an inpatient basis;
2. it is under the supervision of a staff of physicians;
3. it provides twenty-four (24) hour a day nursing service by registered graduate nurses (R.N.'s);
4. it is duly licensed as a Hospital except that this requirement will not apply in the case of a state tax-supported institution; and
5. it is not, other than incidentally, a place for rest, a place for the aged, a nursing home or custodial or training type institution, or an institution which is supported in whole or in part by a federal government fund.

Hospital shall also mean, where appropriate in context, Ambulatory Surgical Center, which means any public or private state licensed and approved (whenever required by law) establishment with an organized medical staff of physicians, permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, continuous physician services and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

Illness - A bodily disorder, disease, physical sickness, of a Covered Person. A recurrent illness will be considered one illness. Concurrent illnesses will be considered one illness unless the concurrent illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one illness.

Intensive Care Accommodation - An accommodation which is reserved for critically and seriously ill patients requiring constant audio-visual observation as prescribed by the attending Physician, and which provides room and board, nursing care by nurses whose duties are confined to care of patients in the intensive care accommodation, and special equipment or supplies immediately available on a standby basis segregated from the rest of the Hospital's facilities.

Loss of Coverage - Loss as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or exhaustion of COBRA coverage. "Loss of coverage" does not include loss due to failure to pay premiums on a timely basis, a voluntary election to terminate such coverage, or termination of coverage for cause (such as making a fraudulent claim).

Maximum Benefit - The amount of the Maximum Benefit is shown in the Schedule of Benefits. It applies separately to Covered Expenses incurred by you for yourself and on behalf of each of your Dependents. The Lifetime Maximum is applicable to all benefits paid for an employee or dependent under the Plan during all period(s) of eligibility. No restoration of the Lifetime Maximum will result from a loss of coverage from a leave of absence, lay-off, or termination of employment.

Medicaid – the medical benefits provided by Title XIX of the Social Security Act, as amended.

Medically Necessary or (Medical Necessity) - means the criteria we use to determine the Medical Necessity of Comprehensive Medical Expense under this plan.
To be Medically Necessary, Covered Services must;

a. Be rendered in connection with an Injury or Sickness;
b. Be consistent with the diagnosis and treatment of your condition;
c. Be in accordance with the standards of good medical practice;
d. Not be considered Experimental or Investigative; and
e. Not be for your convenience or your Physician's convenience.

To be Medically Necessary, Covered Services must also be provided at the most appropriate level of care or in the most appropriate type of health care facility. Only your medical condition (not the financial status or family situation, the distance from a Facility or any other non-medical factor) is considered in determining which level of care or type of health care facility is appropriate.

In order for us to pay covered Services, the services must be Medically Necessary. Any service failing to meet the Medical Necessity Criteria may be the Covered Person's liability.

Medicare – the medical benefits provided by Title XVIII of the Social Security Act, as amended.

Mental and Emotional Condition - A condition characterized by abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional, or behavioral disturbances are the dominant feature. Mental and Emotional Conditions include mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions, whether organic or non-organic, whether biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis, or inducement.

Named Fiduciary - The person who has the authority to control and manage the operation and administration of the Plan.

Out-of-Pocket Maximum – Out-of-Pocket is that portion of Covered Expenses for which the Covered Person is responsible after Plan benefits have been paid. Covered Expenses are payable at the Benefits (percentages) Payable each calendar year until the Individual (or Family) Out-of-Pocket maximum* shown in the Schedule of Benefits is reached. Then, Covered Expenses incurred by a Covered Person (or Family) will be payable at 100% for the rest of the calendar year. * The Out-of-Pocket Maximums are combined. Amounts which are applied toward satisfaction of the PPO Out-of-Pocket Maximum will be applied toward the Out-of – Network Out-of-Pocket Maximum, and vice versa.

Exceptions:

- The following expenses will not be applied toward the satisfaction of the Out-of-Pocket Maximums, nor will benefits for these expenses ever be payable at 100%: Any Co-Pays, Penalties, or any covered expenses for which benefits were initially paid at 100%.)
- When there is other secondary coverage for the same illness or injury for which benefits are payable, the Plan will continue to pay at the applicable co-insurance percentage.

Participant - any Employee or dependent meeting the eligibility requirement and who is covered under this Plan.

Physician or Surgeon - Any professional practitioner who holds a lawful license authorizing the person to practice medicine or surgery in the locale in which the service is rendered, limited to a Doctor of Medicine (M.D.) a Doctor of Osteopathy (D.O.), a Doctor of Podiatric Medicine (D.P.M.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Chiropractic (D.C.), a Doctor of Optometry (O.D.),or a licensed midwife.

Plan Administrator - The person responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services.

Preferred Provider Organization - This Preferred Provider Option is a health care benefit program designed to give the Covered Person a financial incentive to use a designated group of Hospitals and Physicians. The choice of Preferred Providers is based on a range of services, geographic locations, cost-effectiveness, and quality health care.

As a Covered Person under the Preferred Provider Option, the Covered Person will receive a directory of participating Hospitals and Physicians. He will also receive notice of changes to the list of Preferred Providers.

Under this option, the Covered Person will continue to have complete freedom of choice of Hospitals and Physicians. However, the Major Medical Reimbursement Percentage may be greater if he uses the services of a Preferred Provider.

Definitions:

Provider - means any health care facility (for example, a Hospital) or person (for example, a Physician) duly licensed to render covered medical care or services.

Preferred Provider - means a Provider who has entered into an agreement with the preferred provider organization, to provide services to individuals enrolled as members of the organization.

Non-Preferred Provider - means a Provider that does not meet the definition of Preferred Provider.

Emergency - means a sudden, unexpected medical condition that without immediate medical attention could result in death or cause impairment to bodily functions.

If the Covered Person receives treatment or services as a result of an Emergency, benefits will be paid at the PPO Benefits percentage, whether or not the services were performed by a Preferred Provider. If services are not offered by a Preferred Provider or if a Covered Person lives or is traveling outside of the geographical area (more than 50 miles) of the Preferred Provider Organization (PPO), benefits will be paid at the PPO Benefits percentage. However, in both instances, the individual may be responsible for charges in excess of the Reasonable and Customary Charge.

Proof of Loss: Proof of Loss constitutes a claim submitted by the participant which includes: patient name, member name, provider of services, place of service, date(s) of service, diagnosis, description of services rendered, and extent of the loss. A claim is not considered received if any of this information is omitted.

Provider - An Individual who is:
- Licensed to perform certain health care services and who is acting within the scope of his license; OR
- In the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

And who is an:
- Audiologist
- Certified or Registered Nurse Midwife
- Certified Registered Nurse Anesthetist (C.R.N.A.)
- Doctor of Chiropractic (D.C.)
- Licensed Clinical Social Worker (L.C.S.W.)
- Licensed Family Therapist (L.F.T.)
- Licensed Pharmacist
- Licensed Practical Nurse (L.P.N.)
- Licensed Vocational Nurse (L.V.N.)
- Occupational Therapist (O.T.R.)
- Physical Therapist (P.T. or R.P.T.)
- Physician – (see definition of “Physician or Surgeon”)
- Podiatrist or Chiropodist (D.P.M., D.S.P., or D.S.C.)
- Psychologist. As used herein, the term Psychologist shall include only a practitioner who is duly licensed or certified in the state where the service is rendered, has a doctorate degree in psychology, and has had at least two (2) years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology.
- Registered Nurse (R.N.)
- Registered Nurse Practitioner
- Regulated Physician's Assistant
- Respiratory Therapist
- Speech Therapist

A “Provider” will also include the following when appropriately-licensed and providing services which are covered by the Plan:
- Facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Skilled Nursing Facilities, etc.; and
- Birthing Centers;
- Freestanding Public Health Facilities;
- Dialysis and Outpatient clinics under the direction of a Physician (M.D.);
- Home Health care agencies;
- Hospice;

- Medical Supply/equipment companies;
- Portable x-ray companies;
- Independent laboratories;
- Blood banks;
- Ambulance companies;
- Urgent Care centers.

Qualified Medical Child Support Order - (QMCSO) is a judgement, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction, and satisfies all of the following requirements:

1. the order specifies your name and last known address, and the child's name and last known address;
2. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
3. the order states the period to which it applies; and
4. the order specifies each plan that it applies to.

The Qualified Medical Child Support Order may not require the health plan to provide coverage for any type of form of benefit not otherwise provided under the plan.

Reasonable and Customary Amount - The lesser of the following, with respect to a service rendered or supply furnished:

- The usual charge made by the provider for such service or supply; or,
- The charge agreed upon by the Plan Administrator & the Preferred Provider Organization; or,
- The prevailing charge for the same or comparable service or supply made by most providers in the same area.

The Plan Administrator has the discretionary authority to determine whether a charge is Reasonable and Customary. Such determination will consider the nature and severity of the condition being treated, any medical complications, and any unusual circumstances that would require more time, skill or expertise.

Room and Board - The Hospital's charge for room and linen service; dietary service including meals, special diets and nourishments; and general nursing service.

Significant Break in Coverage - A period of 63 (or more) days without Creditable Coverage. Periods of no coverage during an HMO affiliation period or Waiting Period shall not be taken into account for purposes of determining whether a Significant Break in Coverage has occurred.

Skilled Nursing Facility - is a facility that fully meets all of these tests:

a. It is licensed to provide for persons convalescing from Injury or Sickness, professional nursing services on an inpatient basis. The service must be rendered by a registered nurse (RN) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities must be provided.
b. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or a registered nurse.
c. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
d. It maintains a complete medical record on each patient.
e. It has an effective utilization review plan.

f. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
g. It is approved and licensed by Medicare.

Special Enrollee - An Employee or Dependent who has initially denied coverage under this plan due to other health coverage, and who is entitled to and who requests Special Enrollment (as described in the Eligibility Provision): i) within 30 days of losing other health coverage under the following circumstances: as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or exhaustion of COBRA coverage. "Loss of coverage" does not include loss due to failure to pay premiums on a timely basis, a voluntary election to terminate such coverage, or termination of coverage for cause (such as making a fraudulent claim); or ii) because of a newly acquired Dependent, within 30 days of the marriage, birth, adoption, or placement of adoption.

Spouse - An individual of the opposite sex who is legally married to a Participant and who is a resident of the same country in which the Participant resides.

Third Party Administrator (TPA)/Plan Supervisor - The person or firm providing services to the Employer in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it.

Total Disability or Totally Disabled - A condition wherein:
a. the Employee is prevented, solely because of an injury or sickness, from engaging in his regular or customary occupation and is performing no work of any kind for compensation or profit; or
b. the Dependent is prevented, solely because of an injury or sickness, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

Waiting Period - The period that must pass under this Plan (or for purposes of determining Creditable Coverage the Waiting Period under any other health plan) before an Employee or Dependent is eligible to enroll in the Plan.

X. HOW TO FILE A CLAIM

A. CLAIM FILING PROCESS

Once you have gained eligibility under the Plan, the Plan has the responsibility of processing your claim as quickly as possible and paying the maximum benefits allowable within the scope of the Plan. In this process, you must also assume some responsibility.

To assist in processing your claim, please follow the steps listed below in the order in which they appear.

- Complete a Statement of Claim form and submit the completed form, along with any bill*, to the address on your health coverage identification card.
- Detailed itemized bills* may be submitted by you or by the healthcare provider to the address listed on your health coverage identification card.
- *All bills must include the following:
  - patient name
  - dates of service
  - itemized charges
  - diagnosis
  - description of service
  - name and address of provider
- Forward your completed form, with all itemized bills attached to the address indicated on the I.D. Card.

B. FOREIGN CLAIMS

In the event a Covered Person incurs a Covered Expense in a foreign county, the Covered Person shall be responsible for providing the following before any benefits are payable:

- The claim form, provider, invoice or any other documentation required to process the claim must be submitted in the English language.
- The charges for services must be converted into dollars.
- A current conversion chart validating the conversion from the foreign country's currency into dollars.

C. PAYMENT AND ASSIGNMENT OF BENEFITS

Benefits which are payable under this Plan shall be paid to you, whether the claim is made on behalf of yourself or one of your dependents, unless you have assigned the benefits. You may assign benefits which are payable to you under this Plan, but only to a Physician, hospital, dentist, optician, optometrist or any other legally qualified practitioner practicing within the scope of his license.

D. NOTICE AND AFFIRMATIVE PROOF OF LOSS

A written notice of the injury or of the illness for which you are making claim must be given to the Plan Office within 45 days of the first day of the illness or injury for which claim is made and all forms, bills and information necessary to pay the claim must be provided within 180 days of the first day of the illness or injury for which claim is made.

A notice given to the Plan Office at their principal address with sufficient information to identify the Covered Person shall be considered as compliance with this provision. If the individual does not furnish notice and data within the time provided by the Plan, such lack of notice will not jeopardize the claim if it was shown that it was not reasonably possible to furnish such notice when required, but in no event will a claim be considered if submitted more than 180 days from the date of loss.

E. CORRESPONDENCE FROM THE PLAN OFFICE

From time to time you will be contacted by the Plan Office to provide additional information necessary in order to completely and thoroughly determine the benefits payable on your claims. It is in your best interest to respond to such requests as quickly as possible since failure to do so will only result in additional delay in the handling of your claim and possibly even the denial of benefits.

The Plan Office will contact you directly by mail and specify the nature of the information it needs. A standard form will be used for this purpose, and the appropriate section will be checked and, if need be, written instructions will be stated clearly on the form. **THIS FORM IS NOT A DENIAL OF YOUR CLAIM -** it is simply a request for additional information. In the event of the denial of claim, you will receive a written narrative statement explaining the reason for the denial and the appropriate provisions upon which that decision is based.

Should you be confused as to what information has been requested, please either contact the Plan Office by mail or by telephone.

F. CLAIMS REVIEW AND APPEAL PROCEDURES

The procedures described below will be followed when making a determination on your claim for benefits under the plan.

Post-service claims

If you file a claim for a benefit that relates to a service that has already been provided and your claim is denied in whole or in part, you will be notified of the denial within a reasonable period of time, but not later than 30 days after receipt of the completed claim. This period may extend up to 15 days if it is determined that the extension is necessary due to matters out of the administrator's control. If an extension is necessary, you will be notified before the end of the original 30-day period of the circumstances requiring the extension and the date by which a decision is expected. If such an extension is necessary because you did not submit all the information necessary to decide the claim, the notice of extension will specifically describe the additional information required. You will have at least 45 days to provide the requested information. If you deliver the information within the time specified, the 15-day extension period will begin after you provide the information. Any notice you receive regarding an adverse decision on your claim will meet the requirements described below under the heading "Manner and Content of Notice".

Pre-service claims

You must submit a claim to the plan that includes your name, the specific medical condition or symptom for which you are seeking medical attention and the specific treatment, service, or product for which you are seeking approval. You will be notified of the approval or denial of your claim within a reasonable period of time appropriate to the "medical exigencies", but not later than 15 days of receipt of your claim. If it is determined that you have not followed the proper procedures for filing a claim for benefits described above, or that more information is needed before processing your request, you will be notified within five days. You may be asked to explain or describe the "medical exigencies" in existence that could affect the timing of the decision.

If special circumstances arise beyond the administrator's control, the period within which to render a decision may be extended by an additional 15 days. If an extension is necessary, you will be notified prior to expiration of the initial 15 day period of the circumstances requiring the extension of time and the date by which a decision is expected. If an extension is necessary because you have not submitted all the information necessary to decide your claim, the notice of extension will specifically describe the additional information required. You will have at least 45 days to provide the requested information. Any notice you receive regarding an adverse decision on your claim will meet the requirements described below under the heading the "Manner and Content of Notice".

Urgent Care

A claim is an "urgent care claim" if processing the claim within the time frame described above could seriously jeopardize your life, health, or ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment requested in your claim. The following procedures will apply to any urgent care claim:

1. You will be notified of the determination as soon as possible, taking into account the medical exigencies, but no later than 72 hours after your claim is received. You may be asked to explain the medical exigencies relating to your claim.
2. You may be notified orally if it is determined that your claim is denied, as long as you are given written notification within three days after the oral notification.
3. If you do not provide sufficient information to determine whether or to what extent the benefits you seek are covered or payable under the plan, you must be notified within 24 hours of the specific information that you must submit.
4. If you are notified that you need to provide additional information, you will have at least 48 hours in which to provide the additional information.
5. If you have been asked to provide additional information, you will be notified of the decision no later than 48 hours after receipt of the requested information, or, if you do not provide the requested information, you will be notified 48 hours after the end of the period of time that you were given to provide the information.
6. The notice of any adverse decision on your claim will meet requirements described below under the heading "Manner and Content of Notice". Any adverse benefit determination will describe the expedited review process applicable to urgent care claims.

Concurrent Care Decisions

If the plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, the following will apply:

1. If the plan reduces or terminates the plan or course of treatment (other than by plan amendment) before the end of the period of time or number of treatments, you will be notified sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of the plan's decision before it becomes effective.
2. If you make a request to the plan to extend a particular course of treatment beyond the already approved time or number, and the failure to extend the time period or course of treatment could seriously jeopardize your life, health, or the regaining of maximum function, or, in the opinion of a physician with knowledge of your medical condition, failure to extend the time period or course of treatment would subject you to severe pain that cannot otherwise be adequately managed, you will be notified of the decision within 24 hours of receipt of your request, as long as you make your request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.
3. The notice of any adverse benefit determination will meet the requirements described below under the heading "Manner and Content of Notice".

APPEAL

Post-service claims

If your claim is denied, you have 180 days from the receipt of the decision to appeal to the Plan Administrator for a review of the denial. Please send your request for a review to:

Star Transportation, Inc. Employee Benefit Plan
c/o North America Administrators, L.P.
P.O. Box 25207
Nashville, Tennessee 37202

The Plan Administrator's decision on appeal will be given to you in writing within 60 days after receipt of your written request for review, unless the Plan Administrator determines that special circumstances require an additional period, up to 60 days. If it is determined that an extension is necessary, you will be sent written notification within the original 60-day period of the special circumstances requiring the extension and the date by which a determination is expected to be rendered. Any notice you receive regarding an adverse decision on your claim will meet the requirements described below under the heading "Manner and Content of Notice". The following will apply to your right of appeal:

1. You may submit written comments, documents, records and other information in support of your appeal.
2. You will have access free of charge, upon request, to copies of all relevant documents, records, and other information, as described by applicable U.S. Department of Labor regulations.
3. The review on appeal will take into account all comments, documents, records, and other information relating to the claim, whether or not presented or available at the initial determination.
4. The initial determination will not be afforded any deference in appeal process.
5. The review will be conducted by a person different from the person who made the initial determination and who is not the original decisionmaker's subordinate.
6. If the decision is made, in whole or in part, on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the Plan Administrator shall consult with a health care professional with appropriate training and experience.
7. The health care professional will not be individual who was consulted during the initial determination, or that person's subordinate.
8. You will be provided with the name of any medical or vocational expert who advised the Plan with regard to your claim.

Urgent Care

If your claim was processed as an "urgent care" claim and the claim is denied, you may make a request for an expedited review of the determination orally or in writing. All necessary information regarding the review may be transmitted between you and the plan by telephone, facsimile, or other available similarly expeditious method. You must be notified of the determination by any of the methods mentioned above as soon as possible, taking into account the medical exigencies, but no later than 72 hours after your request for review is received. You may be asked to explain the medical exigencies that apply to your request for review. The notice of any adverse determination will meet the requirements described under the heading "Manner and Content of Notice on Appeal".

Pre-service claims

If you appeal the determination with respect to a pre-service claim that was denied, you will be notified of the determination within a reasonable period of time appropriate to the medical circumstances, but in no case later than 30 days. The notice of any adverse determination will meet the requirements described below under the heading "Manner and Content of Notice on Appeal".

Manner and Content of Notice on Appeal

A notice that your request on appeal is denied will be given in writing or electronically and will:

1. State the specific reason or reasons for the determination.
2. Reference the specific plan provisions upon which the determination is based.
3. State that you are entitled access, free of charges, upon request, to all documents records and other information relevant to your claim.
4. Describe your right to bring civil suit under federal law.
5. Disclose any internal rule, guideline, protocol or similar criterion that was relied upon in making the adverse determination (or a statement that such information will be provided free of charge upon request).
6. Explain the scientific or clinical judgment for a benefit determination which was based upon a medical necessity or experimental treatment, or other similar exclusion or limit by applying the terms of the plan to your circumstances (or state that this explanation will be provided free of charge upon request).
7. State that you or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency.

The following amendment to the **Star Transportation, Inc. Bronze** Employee Benefit Plan is effective 01/01/09. This is a permanent addition to your plan and should be attached to your plan booklet.

AMENDMENT I

Page 5, I. SCHEDULE OF BENEFITS, B. COMPREHENSIVE MEDICAL BENEFITS, the following is hereby amended:

	PPO Benefits	NON-PPO Benefits
Deductible:		
Individual	$1,000	$2,000
Family Deductible	$1,500	$3,000
Emergency Room Charges	70%	50%
- co-pay waived if admitted	$250.00 Co-payment per visit.	$250.00 Co-payment per visit.

Page 7, I. SCHEDULE OF BENEFITS, C. PRESCRIPTION DRUG CARD BENEFIT, the following is hereby added:

Deductible .... $50.00 per person

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Star Transportation, Inc.

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Date