HANFORD EMPLOYEE WELFARE TRUST (HEWT)

SUMMARY PLAN DESCRIPTION

Medical Plan

for

Retired Employees Age 65 and Over

Effective Date: January 1, 2007

Medical Claims Administered by UnitedHealthcare

Group Number: 702633

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Introduction

The Hanford Employee Welfare Trust (HEWT) is pleased to provide you with this Summary Plan Description (SPD) which describes your Benefits, as well as your rights and responsibilities, under the Plan.

You and you your Eligible Spouse may enroll in this plan if you are an Eligible Person as defined in Section 10: Glossary of Defined Terms. Under certain circumstances, eligible children may also be enrolled.

This document describes Benefits for:

> The ***HEWT Medical Plan for Retired Employees Eligible for Medicare*** - applies ONLY to retired employees over 65 (and their eligible/enrolled dependents, regardless of their ages). UnitedHealthcare can confirm whether this plan applies to you.
>
> ***Medicare pays primary to this Plan for Eligible Persons who are Medicare eligible***. Please read the Medicare information under Section 7, Coordination of Benefits to see how Medicare works with this Plan.

How to Use this Document

We encourage you to read your SPD and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitation of this SPD by reading (Section 1: What's Covered--Benefits) and (Section 2: What's Not Covered--Exclusions). You should also carefully read

To continue reading, go to right column on this page.

(Section 9: General Legal Provisions) to better understand how this SPD and your Benefits work. You should call the Claims Administrator if you have questions about the limits of the coverage available to you.

Note that prescription drugs are provided through a separate program administered by Express Scripts. This program is described in the Prescription Drug Section of this document.

Many of the sections of the SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. We encourage you to keep your SPD and any attachments for your future reference.

Please be aware that your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Information About Defined Terms

Because this SPD is a legal document, we want to give you information that will help you better understand it. Certain capitalized words have special meanings. We have defined these words in Section 10: Glossary of Defined Terms. Refer to this section as you read the document to have a better understanding of the SPD and of your Plan.

The words "we," "us," and "our" in this document refer to the **Plan Administrator** which is the Hanford Employee Welfare Trust (HEWT). The words "you" and "your" refer to Retirees and Dependents who are Covered Persons as the term is defined in Section 10: Glossary of Defined Terms.

To continue reading, go to left column on next page.

Your Contribution to the Benefit Costs

The Plan requires Retirees to contribute toward the cost of the coverage. Contact the Plan Administrator for information about the portion of the plan cost for which you may be responsible. The contributions you are required to make will be adjusted from time to time by the Plan Administrator in its sole discretion.

Customer Service and Claims Submittal

Please make note of the following information that contains Claims Administrator department names and telephone numbers.

The term **Claims Administrator** refers to UnitedHealthcare. Following are important Claims Administrator department names and toll free telephone numbers:

Customer Service Representative (questions regarding Coverage or procedures - Also shown on your ID card.)

Customer Service Representative (coverage or claims questions)
1-866-249-7606

Prescription Drug Program (Express Scripts) See page 70

Claims Submittal Address:

UnitedHealthcare Insurance Company

P.O. Box 30555

Salt Lake City, Utah 84130-0555

To continue reading, go to right column on this page.

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

UnitedHealthcare Insurance Company - Appeals

P.O. Box 30432

Salt Lake City, Utah 84130-0432

Internet:

We also encourage you to visit the Claims Administrator's website, **www.myuhc.com.**, to take advantage of several self-service features including: viewing your claims' status, ordering ID cards and finding Physicians in your area.

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Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Maximum Plan Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 2: What's Not Covered--Exclusions).

Accessing Benefits

You can choose to receive Benefits from any Physician or provider.

You should show your identification card (ID card) every time you request health care services so that the provider will know that you are enrolled under the Plan.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Plan is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in (Section 8: When Coverage Ends) occurs.

To continue reading, go to right column on this page.

- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

Copayment

Copayment is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Copayment, see (Section 10: Glossary of Defined Terms). Copayment amounts are listed on the following pages next to the description for each Covered Health Service. Please note that when Copayments are calculated as a percentage (rather than a set dollar amount) the percentage is based on Eligible Expenses.

Eligible Expenses

Eligible Expenses are the amount that we will pay for Benefits as determined by us or by our designee. In almost all cases, our designee is the **Claims Administrator.** For a complete definition of Eligible Expenses that describes how we determine payment, see (Section 10: Glossary of Defined Terms).

We have delegated to the Claims Administrator the discretion and authority to initially determine on our behalf whether a treatment or supply is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

You are responsible for paying, directly to the provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

Special Note Regarding Medicare

When Medicare is the primary payer, we will pay as secondary payer as described in (Section 7: Coordination of Benefits).

To continue reading, go to left column on next page.

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms).	$100 per Covered Person per calendar year.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).	$750 per Covered Person per calendar year. The Out-of-Pocket Maximum does include the Annual Deductible.
Maximum Plan Benefit	The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Plan. For a complete definition of Maximum Plan Benefit, see (Section 10: Glossary of Defined Terms).	$250,000 per Covered Person.

Benefit Information

Description of Covered Health Service	Your Copayment Amount %Coinsurance is based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Acupuncture Services Acupuncture services for pain therapy when both of the following are true: • Another method of pain management has failed. • The service is performed by a provider in the provider's office. Where such Benefits are available, acupuncture is a Covered Health Service for the treatment of: • Nausea of chemotherapy, or • Post-operative nausea, or • Nausea of early Pregnancy. Benefits are limited to 20 visits per calendar year.	15%	Yes	Yes
2. Ambulance Services Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed. Transportation by professional ambulance, other than air ambulance, to and from a medical facility. Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment.	*Ground Transportation:* 15% *Air Transportation:* 15%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount %Coinsurance is based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
3. Audiologists Audiologist services by a licensed or certified audiologist for physician prescribed hearing evaluations to determine the location of a disease within the auditory system; for validation or organicity tests to confirm organic hearing problem. Benefits are limited to one exam per calendar year. Charges for services relating to hearing aids or basic hearing evaluations, are not covered.	15%	Yes	Yes
4. Dental Services - Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be both of the following: • Started within three months of the accident.	15%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount %Coinsurance is based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Completed within 12 months of the accident. Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.			
5. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable. • Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment. Examples of Durable Medical Equipment include: • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen concentrator units and the rental of equipment to administer oxygen. • Delivery pumps for tube feedings. • Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service, including necessary adjustments to shoes to accommodate braces.	15%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount %Coinsurance is based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions. We provide Benefits for a single unit of Durable Medical Equipment (example one insulin pump) and provide repair for that unit. Benefits are provided for the replacement of a type of Durable Medical Equipment once every three calendar years. Maximum lifetime Benefits for the purchase and repair of Durable Medical Equipment are limited to $50,000.			
6. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in (Section 3: Obtaining Benefits).	$75 per visit plus 15%	No	Yes
7. Home Health Care Services received from a Home Health Agency that are both of the following: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required.	15%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount %Coinsurance is based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true: • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a Physician. • It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair. • It requires clinical training in order to be delivered safely and effectively. • It is not Custodial Care. A service will not be "skilled" simply because there is not an available caregiver. Benefits are limited to 120 visits per calendar year. One visit equals two hours of skilled care services in any 24 hour period.			
8. Hospice Care Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency.	15%	Yes	Yes
9. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for:	$100 per visit then 15%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount %Coinsurance is based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds).			
10. Injections received in a Physician's Office Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	15% per injection	Yes	Yes
11. Maternity Services Benefits for Pregnancy for your Spouse will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. We will pay Benefits for an Inpatient Stay of at least: • 48 hours for the mother following a vaginal delivery. • 96 hours for the mother following a cesarean section delivery. If the mother agrees, the attending provider may discharge the mother earlier than these minimum time frames.	15%	Yes	Yes
12. Mental Health and Substance Abuse Services - Outpatient Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including: • Mental health, substance abuse and chemical dependency evaluations and	15%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount %Coinsurance is based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy). • Crisis intervention. • Psychological testing. Benefits for Substance Abuse Services are limited to 30 visits per calendar year.			
13. Mental Health and Substance Abuse Services - Inpatient and Intermediate Mental Health Services and Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being. For an Inpatient Stay, the stay is covered on a Semi-private Room basis. Benefits for Substance Abuse Services are limited to 60 days per calendar year.	15%	Yes	Yes
14. Nutritional Counseling Covered Health Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Some	15%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount %Coinsurance is based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
examples of such medical conditions include: • Diabetes mellitus. • Coronary artery disease. • Congestive heart failure. • Severe obstructive airway disease. • Gout. • Renal failure. • Phenylketonuria. • Hyperlipidemias. Benefits are limited to three individual sessions during a Covered Person's lifetime for each medical condition.			
15. Outpatient Surgery, Diagnostic and Therapeutic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Surgery and related services. • Lab and radiology/X-ray. • Mammography testing. • Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy). Benefits under this section include only the facility charge and the charge for	15%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount %Coinsurance is based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under *Professional Fees for Surgical and Medical Services* below. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.			
16. Physician's Office Services Covered Health Services received in a Physician's office including: • Treatment of a Sickness or Injury. • Preventive medical care. • Voluntary family planning. • Routine well woman examinations, including pap smears, pelvic examinations and mammograms. • Routine well man examinations, including PSA tests. • Routine physical examinations, including hearing screenings. • Immunizations. Preventive care is limited to $400 per Calendar Year.	15%	Yes	Yes
17. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.	15%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount %Coinsurance is based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.			
18. Prosthetic Devices Prosthetic devices that replace a limb or body part including: • Artificial limbs. • Artificial eyes. • Breast prosthesis If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device. The prosthetic device must be ordered or provided by, or under the direction of a Physician. We provide Benefits for a single purchase, including repairs, of a type of prosthetic device. Benefits are provided for the replacement of each type of prosthetic device every five calendar years. Lifetime Maximum Benefits for the purchase and repairs of prosthetic devices is limited to $10,000.	15%	Yes	Yes
19. Reconstructive Procedures Reconstructive procedures - services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function it is meant that the target organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside	15%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount %Coinsurance is based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
of the nose so that a person's breathing can be improved or restored. Cosmetic Procedures - services are considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent "bump" would be a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on function like breathing. This Plan does not provide Benefits for Cosmetic Procedures. Some services are considered cosmetic in some circumstances and reconstructive in others. This means that there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations, the purpose would be to improve appearance and function (such as vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions improvement in appearance is the primary purpose of the procedure. Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry.			
20. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy. • Occupational therapy. • Speech therapy.	15%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount %Coinsurance is based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. The Plan gives the Claims Administrator the right to exclude from coverage rehabilitation services that are not expected to result in significant physical improvement in your condition within two months of the start of treatment. In addition, the Claims Administrator has the right to deny Benefits if treatment ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring. Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly. Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Benefits are limited as follows: • 30 visits of physical therapy per calendar year. • 30 visits of occupational therapy per calendar year. • 30 visits of speech therapy per calendar year. • 20 visits of pulmonary rehabilitation therapy per calendar year.			

Description of Covered Health Service	Your Copayment Amount %Coinsurance is based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• 20 visits of cardiac rehabilitation therapy per calendar year.			
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Benefits are limited to 60 days per calendar year. Please note that, in general, the intent of skilled nursing is to provide Benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting. The Covered Person is expected to improve to a predictable level of recovery. Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, Benefits are NOT available when these services are required intermittently (such as physical therapy three times a week). Benefits are NOT available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to	15%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount %Coinsurance is based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
an extent that might allow for a more independent existence. (Custodial, domiciliary or maintenance care may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)			
22. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to one visit and treatment per day. Please note that the Plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition when the therapy, service or supply ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Benefits for Spinal Treatment are limited to 20 visits per calendar year.	15%	Yes	Yes
23. Transplantation Services Covered Health Services for organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or	15%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount %Coinsurance is based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Investigational Service or an Unproven Service.			
24. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.	15%	Yes	Yes

Section 2: What's Not Covered--Exclusions

This section contains information about:

- How headings are used in this section.
- Medical services that are not covered. We call these ***Exclusions***. It's important for you to know what services and supplies are not covered under the Plan.

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings. The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

Plan Exclusions

We will not pay or approve Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

To continue reading, go to right column on this page.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in (Section 1: Covered Health Services) or through a Rider to the SPD.

A. Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
7. Services received by a naturopath.
8. Holistic or homeopathic care.

B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners.
   - Air purifiers and filters.
   - Batteries and battery chargers.
   - Dehumidifiers.
   - Humidifiers.

To continue reading, go to left column on next page.

6. Devices and computers to assist in communication and speech.
7. Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools).

C. Dental

1. Dental care except as described in (Section 1: What's Covered--Benefits) under the heading *Dental Services - Accident Only*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
   — Extraction, restoration and replacement of teeth.
   — Medical or surgical treatments of dental conditions.
   — Services to improve dental clinical outcomes.
3. Dental implants.
4. Dental braces.
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
   — Transplant preparation.
   — Initiation of immunosuppressives.
   — The direct treatment of acute traumatic Injury, cancer or cleft palate.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.

D. Drugs

Prescription Drug Benefits are provided through a separate program administered by Express Scripts, Inc. See Page 70 for more information.

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1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications.
3. Non-injectable medications given in a Physician's office except as required in an Emergency.
4. Over the counter drugs and treatments.

E. Experimental or Investigational Services or Unproven Services

Experimental or Investigational Services and Unproven Services are excluded. The fact that an Experimental or Investigational Service or an Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

1. Except when needed for severe systemic disease:
   — Routine foot care (including the cutting or removal of corns and calluses).
   — Nail trimming, cutting, or debriding.
2. Hygienic and preventive maintenance foot care. Examples include the following:
   — Cleaning and soaking the feet.
   — Applying skin creams in order to maintain skin tone.
   — Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.
3. Treatment of flat feet.

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4. Treatment of subluxation of the foot.
5. Shoe orthotics.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Elastic stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Syringes.
   - Diabetic test strips.
3. Orthotic appliances that straighten or re-shape a body part (including some types of braces).
4. Tubings, nasal cannulas, connectors and masks are not covered except when used with Durable Medical Equipment (as described in Section 1: What's Covered--Benefits).

H. Mental Health/Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Services for Mental Health and Substance Abuse that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.
3. Treatment for insomnia and other sleep disorders, dementia, neurological disorders and other disorders with a known physical basis.

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4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice.
5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements.
7. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that are any of the following:
   - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
   - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
   - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   - Not consistent with Mental Health/Substance Abuse guidelines or best practices.
8. Pastoral counselors.
9. Treatment provided in connection with autism.
10. Treatment provided in connection with tobacco dependency.
11. Routine use of psychological testing without specific authorization.

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I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Except as described in (Section 1: What's Covered -- Benefits) under *Nutritional Counseling,* nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs.
3. Enteral feedings and other nutritional and electrolyte formulas, supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals except when sole source of nutrition or except when a certain nutritional formula treats a specific inborn error of metabolism.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 10: Glossary of Defined Terms.) Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).

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3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss.
6. Services received from a personal trainer.
7. Liposuction.

K. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography testing.

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L. Reproduction

1. Health services and associated expenses for infertility treatments.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Fees or direct payment to a donor for sperm or ovum donations.
5. Monthly fees for maintenance and/or storage of frozen embryos.
6. Contraceptive supplies and services.
7. Pregnancy Benefits for Dependent Children. Dependent children are only covered for Complications of Pregnancy. The following are not considered Complications of Pregnancy:
   - False labor.
   - Occasional spotting.
   - Rest prescribed by a Physician.
   - Morning Sickness.
   - Other conditions that may be connected with a difficult pregnancy but are not a classifiably distinct complication.
8. Newborn charges and child care.

M. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

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If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

N. Transplants

1. Health services for organ and tissue transplants, except those described in (Section 1: What's Covered--Benefits).
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services for transplants involving mechanical or animal organs.
4. Any solid organ transplant that is performed as a treatment for cancer.
5. Any multiple organ transplant that is not a Covered Health Service.

O. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

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P. Vision and Hearing

1. Purchase cost of eye glasses or contact lenses.
2. Fitting charge for eye glasses or contact lenses.
3. Eye exercise therapy.
4. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as radial keratotomy, laser, and other refractive eye surgery.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in (Section 10: Glossary of Defined Terms).
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
   - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.

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6. In the event that a provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or the Annual Deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be medical or dental in nature, including oral appliances.
9. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
10. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.
11. Non-surgical treatment of obesity, including morbid obesity.
12. Surgical treatment of obesity including severe morbid obesity (with a BMI greater than 35).
13. Growth hormone therapy.
14. Sex transformation operations.
15. Custodial Care.
16. Domiciliary care.
17. Private duty nursing.
18. Respite care.
19. Rest cures.
20. Psychosurgery.
21. Treatment of benign gynecomastia (abnormal breast enlargement in males).

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22. Medical and surgical treatment of excessive sweating (hyperhidrosis).
23. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
24. Appliances for snoring.
25. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
26. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.
27. Any charge for services, supplies or equipment advertised by the provider as free.
28. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
29. Any charges prohibited by federal anti-kickback or self-referral statutes.
30. Chelation therapy, except to treat heavy metal poisoning.
31. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
32. Outpatient rehabilitation services, Spinal Treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
33. Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies.
34. Speech therapy to treat stuttering, stammering, or other articulation disorders.

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Section 3: Obtaining Benefits

This section includes information about:

- Benefits for Covered Health Services.
- Emergency Health Services.

Benefits for Covered Health Services

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider.

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

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Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person must complete an enrollment form. As an Eligible Person, you may also enroll your Eligible Spouse and Eligible Dependent Children. If you do not enroll your Eligible Spouse or Eligible Dependent Children when you enroll, you may not later enroll them. The Plan Administrator or its designee will give the necessary forms to you along with instructions about submitting your enrollment form and any required contribution for coverage. We will not provide Benefits for health services that you receive before your effective date of coverage.

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If You Are Eligible for Medicare

Your Benefits under the Plan may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

Your Benefits under the Plan may also be reduced if you are enrolled in a Medicare+Choice (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in (Section 7: Coordination of Benefits) for more information about how Medicare affects your Benefits from this Plan.

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	Eligible Person usually refers to a former employee of a Sponsoring Employer (or predecessor employer) who meets the eligibility rules established by the Plan Administrator. When an Eligible Person actually enrolls, we refer to that person as a Retiree. For a complete definition of Eligible Person and Retiree, see Section 10: Glossary of Defined Terms. If both Spouses are Eligible Persons, each may enroll as a Retiree or be covered as an Enrolled Dependent of the other, but not both. Except as we have described in Section 4: When Coverage Begins, Eligible Persons may not enroll without our written permission.	We determine who is eligible to enroll under the Plan.
Dependent	Dependent generally refers to the Eligible Person's Eligible Spouse and certain eligible children (Eligible Dependent Child). When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent, Eligible Dependent Child, Spouse, Eligible Spouse, and Enrolled Dependent, see Section 10: Glossary of Defined Terms. Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan unless the Eligible Person is deceased and there is a Surviving Spouse. Dependents other than an Eligible Spouse and/or Eligible Dependent Child as defined in Section 10: Glossary of Defined Terms are not eligible for coverage. If both parents of an Eligible Dependent Child are enrolled in a HEWT-sponsored plan for active employees or retirees, only one parent may enroll the child as an Eligible Dependent.	We determine who qualifies as a Dependent.
Surviving Spouse	Surviving Spouse refers to the Surviving Spouse of an Eligible Person. The Surviving Spouse of an Eligible Person may enroll when he or she attains age 65 if continuously covered under a HEWT-sponsored group health plan up to age 65.	We determine who qualifies as a Surviving Spouse.

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll. This occurs the later of: the date the Retiree retires or reaches age 65.	An Eligible Person may enroll and enroll his or her Eligible Spouse and Eligible Dependent Child only upon first becoming eligible for this Plan. If an Eligible Person does not enroll when first eligible, or enroll his or her eligible Dependents, the Eligible Person or eligible Dependents that are not enrolled may not enroll later. An Eligible Person who enrolls and who thereafter has a new Dependent (by reason of marriage, birth, etc.) may not enroll those new Dependents. Effective on November 1, 2003, retirees who are currently enrolled may elect to drop ("waive") their HEWT-sponsored post-retirement medical coverage for themselves and enrolled dependents, with the ability of a one-time re-enrollment in the future.	Coverage begins on the date identified by the Plan Administrator, if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 31 days of the date the Eligible Person becomes eligible to enroll.

Section 5: How to File a Claim

This section provides you with information about:
- How and when to file a claim.

Filing a Claim for Benefits

When you receive Covered Health Services, you are responsible for requesting payment from us through the Claims Administrator. You must file the claim in a format that contains all of the information required, as described below.

You must submit a request for payment of Benefits within two years after the date of service. If a provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you don't provide this information to us within two years of the date of service, Benefits for that health service will be denied or reduced, in our or the Claims Administrator's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

If a Retiree provides written authorization to allow direct payment to a provider, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Retiree. We will not reimburse third parties who have purchased or been assigned benefits by Physicians or other providers.

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Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

A. Retiree's name and address.
B. The patient's name, age and relationship to the Retiree.
C. The member number stated on your ID card.
D. An itemized bill from your provider that includes the following:
- Patient Diagnosis
- Date(s) of service
- Procedure Code(s) and descriptions of service(s) rendered
- Charge for each service rendered
- Provider of service Name, Address and Tax Identification Number

E. The date the Injury or Sickness began.
F. A copy of your Explanation of Benefits (EOB) from Medicare A and B if you or a dependent for whom a claim is made is age 65 or older. In the absence of an EOB, the Plan will automatically presume enrollment in Medicare A and B as primary coverage and pay benefits on a secondary basis to Medicare A and B.
G. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

Through the Claims Administrator, we will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following is true:

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A. The provider notifies the Claims Administrator that your signature is on file, assigning benefits directly to that provider.
B. You make a written request for the provider to be paid directly at the time you submit your claim.

Benefit Determinations

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45 day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision

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from the Claims Administrator within 15 days of receipt of the claim. If you filed a pre-service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received, and may request a one time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45 day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45 days period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Action

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72-hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

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If you filed an urgent claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received.

If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48 hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the

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timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

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Section 6: Questions and Appeals

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination.

To resolve a question or appeal, just follow these steps:

What to Do First

If your question or concern is about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in (How to File a Claim) you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of the Claims Administrator.

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If you are appealing an Urgent Care Claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below and contact Customer Service immediately.

The Customer Service telephone number, 1-866-249-7606, shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

How to Appeal a Claim Decision

If you disagree with a pre-service or post-service claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination.

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The Claims Administrator (first level appeals) and the Plan Administrator (second level appeals) may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of decision on your appeal as follows:

For appeals of pre-service claims (as defined in How to File a Claim), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by us of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims (as defined in How to File a Claim), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by us of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see "Urgent Claim Appeals that Require Immediate Action" below.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level

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appeal from us as the Plan Administrator. Your second level appeal request must be submitted to us in writing within 60 days from receipt of the first level appeal decision.

The Plan Administrator has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

Please note that our decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, we have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

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Section 7: Coordination of Benefits

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.
- Medicare

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides Benefits to you. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating Benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one benefit plan.

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage

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Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the Benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

1. "Coverage Plan" is any of the following that provides Benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
   a. "Coverage Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical Benefits under group or individual automobile contracts; and Medicare, Parts A and B, or other governmental Benefits, as permitted by law.
   b. "Coverage Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; Benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental Plans, unless permitted by law.

   Each contract for coverage under a. or b. above is a separate Coverage Plan. If a Coverage Plan has two parts and COB

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rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

2. The order of benefit determination rules determine whether this Coverage Plan is a "Primary Coverage Plan" or "Secondary Coverage Plan" when compared to another Coverage Plan covering the person.

   When this Coverage Plan is primary, its Benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's Benefits. When this Coverage Plan is secondary, its Benefits are determined after those of another Coverage Plan and may be reduced because of the Primary Coverage Plan's Benefits.

3. "Allowable Expense" means a health care service or expense, including deductibles and Copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides Benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an Allowable Expense. Dental care, routine vision care, outpatient prescription drugs, and hearing aids are examples of expenses or services that are not Allowable Expenses under the Plan. The following are additional examples of expenses or services that are not Allowable Expenses:

   a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.

   b. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and

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customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

   c. If a person is covered by two or more Coverage Plans that provide Benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   d. If a person is covered by one Coverage Plan that calculates its Benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its Benefits or services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.

   e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed Panel Plan" is a Coverage Plan that provides health Benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes Benefits for services provided by other providers, except in cases of Emergency or referral by a panel member.

6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

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Order of Benefit Determination Rules

When two or more Coverage Plans pay Benefits, the rules for determining the order of payment are as follows:

A. The Primary Coverage Plan pays or provides its Benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.

B. A Coverage Plan that does not contain a coordination of Benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of Benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan Hospital and surgical Benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide Benefits.

C. A Coverage Plan may consider the Benefits paid or provided by another Coverage Plan in determining its Benefits only when it is secondary to that other Coverage Plan.

D. The first of the following rules that describes which Coverage Plan pays its Benefits before another Coverage Plan is the rule to use.

1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a Dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a Dependent; and

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primary to the Coverage Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of Benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.

2. Child Covered Under More Than One Coverage Plan. The order of Benefits when a child is covered by more than one Coverage Plan is:

   a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:

      1) The parents are married;

      2) The parents are not separated (whether or not they ever have been married); or

      3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

   b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.

   c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of Benefits is:

      1) The Coverage Plan of the custodial parent;

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2) The Coverage Plan of the spouse of the custodial parent;

3) The Coverage Plan of the noncustodial parent; and then

4) The Coverage Plan of the spouse of the noncustodial parent.

3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of Benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a Dependent of an actively working spouse will be determined under the rule labeled D(2).

4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of Benefits, this rule is ignored.

5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

6. If a husband or wife is covered under this Coverage Plan as an Retiree and as an Enrolled Dependent, the Dependent Benefits will be coordinated as if they were provided under another Coverage Plan, this means the Retiree's benefit will pay first.

7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

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Effect on the Benefits of this Plan

A. When this Coverage Plan is secondary, it may reduce its Benefits by the total amount of Benefits paid or provided by all Coverage Plans that are primary to this Coverage Plan. As each claim is submitted, this Coverage Plan will:

   1. Determine its obligation to pay or provide Benefits under its plan;

   2. Determine the difference between the benefit payments that this Coverage Plan would have paid had it been the Primary Coverage Plan and the benefit payments paid or provided by all Coverage Plans Primary to this Coverage Plan.

   If there is a difference, this Coverage Plan will pay that amount. Benefits paid or provided by this Coverage Plan plus those of Coverage Plans that are primary to this Coverage Plan may be less than 100 percent of total Allowable Expenses.

B. If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, Benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.

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Medicare Benefits and Eligibility

It is intended that this plan supplement benefits provided by Medicare.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you **should** enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in this Section, we will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare+Choice (Medicare Part C) Plan on a primary basis (Medicare pays before Benefits under the Plan), you **should** follow all rules of that Plan that require you to seek services from that Plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare+Choice Plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

How Medicare Benefits Work

First, this Plan determines the amount payable according to the benefits under the Plan. However, the amount of Covered Expenses is based on the amount of charges allowed under Medicare rules instead of the Reasonable Charges as defined by the Plan. Then, this

To continue reading, go to right column on this page.

Plan subtracts the amount payable under Medicare for the same expenses from Plan benefits. This Plan pays only the difference (if any) between Plan benefits and Medicare benefits.

This Coverage Plan reduces its Benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare Benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled for Medicare. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare Benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare Benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare Benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.

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- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under this Coverage Plan and other Coverage Plans. The Claims Administrator may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining Benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming Benefits.

The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Coverage Plan must give us any facts we need to apply those rules and determine Benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Coverage Plan. We will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means reasonable cash value of the Benefits provided in the form of services.

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Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the Benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

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Section 8: When Coverage Ends

This section provides you with information about all of the following:

- Events that cause coverage to end.
- The date your coverage ends.
- Continuation of coverage under federal law (COBRA).

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General Information about When Coverage Ends

We may discontinue this Benefit Plan and/or all similar benefit Plans at any time.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services that you receive for medical conditions that occurred before your coverage ended, even if the underlying medical condition occurred before your coverage ended.

An Enrolled Dependent's coverage ends on the date the Retiree's coverage ends or sooner if the Retiree chooses to end the Dependent's coverage, the Dependent no longer meets eligibility requirements, or as otherwise set forth in this SPD.

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Events Ending Your Coverage

Coverage ends on the earliest of the dates specified in the following table:

Ending Event	What Happens
The Entire Plan Ends	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Your coverage ends on the date you are no longer eligible to be a Retiree or Enrolled Dependent. Please refer to (Section 10: Glossary of Defined Terms) for a more complete definition of the terms "Eligible Person", "Retiree", "Surviving Spouse", "Employee", "Dependent" and "Enrolled Dependent." Your Enrolled Dependents will cease to be eligible when you are no longer eligible unless your eligibility ends by reason of your death. Death. If you (the Retiree) die, coverage for your Enrolled Dependents may be continued as follows: coverage for an Eligible Dependent Child may continue until the date the Eligible Dependent Child no longer qualifies as an Eligible Dependent Child. Coverage for the Spouse may continue until such time as the Spouse remarries or fails to make the required contributions, if sooner. Remarriage of a Spouse does not render other Enrolled Dependents ineligible. This period of coverage will be credited toward satisfying the maximum coverage provided under COBRA discussed below.
The Claims Administrator Receives Notice to End Coverage	Your coverage ends on the date the Claims Administrator receives written notice from us instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Employee that coverage has ended on the date the Plan Administrator identifies in the notice:

Ending Event	What Happens
Fraud, Misrepresentation or False Information	Fraud or misrepresentation, or because the Retiree knowingly gave us or the Claims Administrator false material information. Examples include false information relating to another person's eligibility or status as a Dependent. During the first two years the Plan is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Plan. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.
Material Violation	There was a material violation of the terms of the Plan.
Improper Use of ID Card	You permitted an unauthorized person to use your ID card, or you used another person's card.
Failure to Pay	You failed to pay a required contribution.
Threatening Behavior	You committed acts of physical or verbal abuse that pose a threat to our staff, the Claims Administrator's staff, a provider, or other Covered Persons.

Continuation of Coverage

If your coverage or that of a Dependent end under the Plan, you or your dependent may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if we are subject to the provisions of COBRA.

If you selected continuation coverage under a prior Plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior Plan or in accordance with the terminating events listed below, whichever is earlier.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about how COBRA may apply to you as a Retiree or Enrolled Dependent, and regarding your right to continue coverage.

If you are the Spouse of a Retiree covered by the Health Plan, you have the right to elect COBRA continuation coverage for yourself if you lose your group health coverage under the Health Plan for any of the following qualifying events:

- Divorce or legal separation from your spouse.

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A dependent child of a Retiree covered by the Health Plan has the right to elect COBRA continuation coverage if the dependent child's group health coverage under the Health Plan is lost for any of the following qualifying events:

- The death of the employee-parent;
- The parents' divorce or legal separation;
- The dependent ceases to be a "dependent child" under the Health Plan.

Electing COBRA Continuation Coverage

Under the law, the covered Retiree or a covered family member has the responsibility to inform the Plan Administrator of the Retiree's divorce or legal separation, or a child losing dependent status under the Health Plan. This notice must be given to the Plan Administrator within sixty (60) days after the later of (1) the date of such an event, or (2) the date on which the affected family member would otherwise lose coverage because of such event. If this notice is not given to the Plan Administrator within the required 60-day period, the affected Retiree or family member will not be entitled to elect COBRA continuation coverage.

The Employer has the responsibility to notify the Plan Administrator of the Retiree's death.

When the Plan Administrator is notified that one of these qualifying events has occurred, the Plan Administrator will in turn notify the appropriate individuals (also called "qualified beneficiaries") that they have the right to elect COBRA continuation coverage. COBRA continuation coverage must be elected by such individuals within sixty (60) days after the later of (1) the date that coverage under the Health Plan would otherwise terminate due to the qualifying event,

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or (2) the date that these individuals are provided with written notification of their right to elect COBRA continuation coverage. If COBRA continuation coverage is not elected within this 60-day period, the Health Plan coverage will end retroactive to the date that coverage would have otherwise ended due to the COBRA qualifying event, and the affected family member will not be entitled to elect COBRA continuation coverage. While an election by a covered spouse will be treated as an election of COBRA continuation coverage by the entire family, each family member may make a separate election as to COBRA continuation coverage. This means that a covered spouse or dependent child may separately elect COBRA continuation coverage. A covered spouse or dependent may elect COBRA continuation coverage even if covered under another group health plan or Medicare prior to electing COBRA continuation coverage.

Extent of Coverage

If continuation of coverage is elected, the Health Plan is required to provide COBRA continuation coverage which, at the time that coverage is being provided, is identical to the coverage provided under the Health Plan to similarly situated Health Plan participants who have not experienced a qualifying event (called "non-COBRA beneficiaries"). For example, if a Retiree dies leaving a spouse and two dependent children covered under the Health Plan, they would be entitled to the same benefits as the covered spouse and dependent children of a Retiree. If the benefits for similarly situated non-COBRA beneficiaries are modified, the changes will apply to those who have COBRA continuation coverage as well.

COBRA continuation coverage may be maintained for up to 36 months.

In general, your covered dependents (if any) will only be given an opportunity to continue the coverage they were receiving

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immediately before the qualifying event. In a few circumstances, however, they may elect alternative coverage that the Plan makes available to Retirees, such as:

(1) If you participate in a region-specific HMO that will not service your health needs in the area to which you are relocating, you must be given an opportunity to elect alternative coverage that the employer makes available to active employees.

(2) You and your covered dependents (if any) will have the same opportunity as a Retiree to change your coverage at open enrollment.

When COBRA Continuation Coverage Ends

The law provides that COBRA continuation coverage will be cut short for any of the following reasons:

(1) Your former Employer no longer provides group health coverage to any of its employees;

(2) The premium for the COBRA continuation coverage is not paid on a timely basis (the first premium payment is payable in a lump sum forty five (45) days after electing COBRA continuation coverage; all subsequent premium payments are payable within thirty (30) days after the due date);

(3) The covered individual first becomes, after the date of the COBRA continuation coverage election, covered under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any preexisting condition of that individual (other than an exclusion or limitation that does not apply to, or is satisfied by, such individual by reason of the Health Insurance Portability and Accountability Act of 1996);

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(4) The covered individual first becomes, after the date of the COBRA continuation coverage election, entitled to Medicare (under Title XVIII of the Social Security Act); or

(5) Upon the occurrence of any event (such as submission of fraudulent claims) by a covered individual that permits termination of Health Plan coverage for cause with respect to similarly situated non-COBRA beneficiaries.

We ask that covered individuals notify the Plan Administrator if an event occurs that is listed in number (3) or (4) above within thirty (30) days after becoming eligible for such other group health plan coverage or entitled to Medicare.

Cost of Coverage

The cost of COBRA continuation coverage will generally not exceed 102% of the cost for coverage under the Health Plan. The cost of COBRA continuation coverage will increase in the middle of the 12-month determination period only in the following instances:

(1) where the qualified beneficiary changes to more expensive coverage, or

(2) where the Health Plan was previously requiring payment of less than the maximum permissible amount.

An individual seeking COBRA continuation coverage is liable for the cost of that coverage during the entire applicable 36-month period (measured from the date that coverage would otherwise end due to the qualifying event). Due to the required sixty (60) day COBRA election period, it is likely that a covered individual will be responsible for retroactive premiums. These premiums must be paid in a lump sum within forty five (45) days after electing COBRA continuation coverage in order for the COBRA continuation coverage to be effective. After that payment, premiums are due on a

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monthly basis. Coverage will terminate if premiums are not paid within thirty (30) days after the date they are due.

An individual need not show proof of insurability to elect COBRA continuation coverage.

Coverage Expires

When COBRA continuation coverage expires after 36 months, an individual has the opportunity to enroll in an individual conversion health plan provided by the Health Plan if such option is otherwise generally available to similarly situated non-COBRA beneficiaries under the group health plan.

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Section 9: General Legal Provisions

This section provides you with information about:
- General legal provisions concerning your Plan.

Plan Document

This Summary Plan Description presents an overview of your Benefits. In the event of any discrepancy between this Summary Plan Description and the official Plan Document, the Plan Document shall govern.

Relationship between Claims Administrator and Us

The relationships between us and the Claims Administrator are solely contractual relationships between independent contractors. The Claims Administrator is not our agent nor our Employee. Neither we nor any of our Employees are agents or Employees of Claims Administrator.

We do not provide health care services or supplies, nor do we practice medicine.

The Claims Administrator is not considered to be an employer or Plan Administrator for any purpose with respect to the administration or provision of Benefits under this Plan.

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The Plan Administrator is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and us is that of Sponsoring Employer and Retiree, Eligible Dependent Child or other classification as defined in the Plan.

Incentives to Providers

The Claims Administrator pays certain providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

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Examples of financial incentives for contracted providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness.
- Capitation - a group of providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a provider within the group to perform or coordinate certain health services. The providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

The methods used to pay specific contracted providers may vary. From time to time, the payment method may change. If you have questions about whether your provider has a contract and if that contract includes any financial incentives, we encourage you to discuss those questions with your provider.

Incentives to You

Sometimes the Claims Administrator may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact the Claims Administrator if you have any questions.

Interpretation of Benefits

We and the Claims Administrator have sole and exclusive discretion to do all of the following:

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- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and Amendments.
- Make factual determinations related to the Plan and its Benefits.

We and the Claims Administrator may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Plan

We reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Plan. Plan Amendments and Riders are effective on the date we specify.

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Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Any change or Amendment to or termination of the Plan, its Benefits or its terms and conditions, in whole or in part, shall be made solely in a written Amendment (in the case of a change or Amendment) or in a written resolution (in the case of a termination), whether prospective or retroactive, to the Plan, in accordance with the procedures established by us. Covered Persons will receive notice of any material modification to the Plan. No one has the authority to make any oral modification to the SPD.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan documents.

Information and Records

At times we or the Claims Administrator may need additional information from you. You agree to furnish us and/or the Claims Administrator with all information and proofs that we may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when we request it we may delay or deny payment of your Benefits.

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By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish us or the Claims Administrator with all information or copies of records relating to the services provided to you. We or the Claims Administrator have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Employee's enrollment form. We and the Claims Administrator agree that such information and records will be considered confidential.

We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, the Claims Administrator, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we or the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as the Plan Administrator.

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Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. If you receive a Benefit payment from the Plan for an Injury caused by a third party, and you later receive any payment for that same condition or Injury from another person, organization or insurance company, we have the right to recover any payments made by the Plan to you. This process of recovering earlier payments is called subrogation. In case of subrogation, you may be asked to sign and deliver information or documents necessary for us to protect our right to recover Benefit payments made. You agree to provide us all assistance necessary as a condition of participation in the Plan, including cooperation and information submitted to or supplied by a workers' compensation, liability insurance carrier, and any medical Benefits, no-fault insurance, or school insurance coverage that are paid or payable.

We shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and Benefits we provided to you from any or all of the following:

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- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as "Third Parties").

You agree as follows:

- To assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- To cooperate with us in protecting our legal rights to subrogation and reimbursement.
- That our rights will be considered as the first priority claim against Third Parties, to be paid before any other of your claims are paid.
- That you will do nothing to prejudice our rights under this provision, either before or after the need for services or Benefits under the Plan.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name.
- That regardless of whether or not you have been fully compensated, we may collect from the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the reasonable value of services provided under the Plan.

To continue reading, go to left column on next page.

- To hold in trust for our benefit under these subrogation provisions any proceeds of settlement or judgment.
- That we shall be entitled to recover reasonable attorney fees from you incurred in collecting proceeds held by you.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval.
- To execute and deliver such documents (including a written confirmation of assignment, and consent to release medical records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as we may reasonably request from you.
- We will not pay fees, costs or expenses you incur with any claim or lawsuit, without our prior written consent.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Plan.

The refund equals the amount we paid in excess of the amount we should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the

To continue reading, go to right column on this page.

amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future Benefits.

Limitation of Action

If you want to bring a legal action against us or the Claims Administrator you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us or the Claims Administrator.

You cannot bring any legal action against us or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring a legal action against us or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against us or the Claims Administrator.

To continue reading, go to left column on next page.

Section 10: Glossary of Defined Terms

This section:
- Defines the terms used throughout this SPD.
- Is not intended to describe Benefits.

Alternate Facility - a health care facility that is not a Hospital, or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:

- Pre-scheduled surgical services.
- Emergency Health Services.
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

An Alternate Facility may also provide Mental Health Services or Substance Abuse Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or revised provisions or Benefits to the Plan. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

To continue reading, go to right column on this page.

Annual Deductible - the amount you must pay for Covered Health Services in a calendar year before we will begin paying for Benefits in that calendar year.

Benefits - your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this SPD and any applicable Riders and Amendments.

Claims Administrator - the company, or its affiliate, that provides certain claim administration services for the Plan.

Congenital Anomaly - a physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Complications of Pregnancy - A condition that requires medical treatment before or after pregnancy ends. The following conditions are considered Complications of Pregnancy:

- Acute nephritis.
- Nephrosis.
- Cardiac decompensation.
- Missed abortion.
- Disease of any of the following body systems:
  - Vascular.
  - Hemopoietic.
  - Nervous.
  - Endocrine.

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- Other medical or surgical conditions as severe as those listed above.
- Pernicious vomiting (Hyperemesis gravidarum).
- Toxemia (Pre-eclampsia).
- Cesarean section.
- Ectopic pregnancy which is ended.
- A natural loss of the fetus during the first 20 weeks of pregnancy.

Copayment - the charge you are required to pay for certain Covered Health Services. A Copayment may be either a set dollar amount or a percentage of Eligible Expenses.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Service(s) -those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not Covered--Exclusions), including Experimental or Investigational Services and Unproven Services.

Covered Health Services must be provided:

- When the Plan is in effect;
- Prior to the effective date of any of the individual termination conditions set forth in this Summary Plan Description; and

To continue reading, go to right column on this page.

- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Covered Person - either the Employee or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Custodial Care - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Eligible Person's legal Spouse or an unmarried Eligible Dependent Child of the Person or the Person's Spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.

To continue reading, go to left column on next page.

- A child for whom legal guardianship has been awarded to the Person or the Person's Spouse.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use in the home.

Eligible Dependent Child – a dependent child of the Eligible Person or the Eligible Person's Spouse who is not able to be self-supporting because of mental retardation or a physical handicap regardless of the age of the child. The child must be primarily dependent upon the Retiree for support and maintenance and may not be regularly employed on a full-time basis. The Retiree must furnish the Claims Administrator with proof of the child's incapacity and dependency including medical examination at our expense, but this information shall not be required more than once a year. An Eligible Dependent Child does not include anyone who is also enrolled as a Retiree. No one may be an Eligible Dependent Child of more than one person. An Eligible Dependent Child may be added at initial enrollment only if he or she has been continuously covered under a HEWT-sponsored health plan at the time of the Eligible Person's enrollment under this Plan. An Eligible Dependent Child shall no longer qualify for enrollment when he or she no longer meets the requirements set forth in this definition and once ineligible may not thereafter be reenrolled.

To continue reading, go to right column on this page.

Eligible Expenses - the amount we will pay for Covered Health Services, incurred while the Plan is in effect, are determined as stated below:

Eligible Expenses are based on available data resources of competitive fees in that geographic area.

Eligible Expenses are determined solely in accordance with the Claim Administrator's reimbursement policy guidelines. The reimbursement policy guidelines are developed, in the Claim Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claim Administrator accepts.

Eligible Person - a former Employee of a Sponsoring Employer or predecessor contractor who retires from active service on or after age 65 and is covered under a HEWT-sponsored group health plan or who retired from active service prior to age 65 and is enrolled in the Hanford Employee Welfare Trust Medical Plan for Retired Employees Under 65 when he or she becomes eligible for this Plan at age 65. An Eligible Person must continuously meet the eligibility criteria as set forth in the Plan Document, Summary Plan Description and Administrative Information, Hanford Retiree Welfare Benefit Plans.

To continue reading, go to left column on next page.

Eligible Spouse - a Spouse of an Eligible Person at the date the Eligible Person leaves active service who is covered under a HEWT-sponsored group health plan up to the date of enrollment in this Plan.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Employee - an Employee of a Sponsoring Employer.

Enrolled Dependent - a Dependent who is properly enrolled under the Plan.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time a determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.

To continue reading, go to right column on this page.

- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law, that is both of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time, as determined by the Plan Administrator, during which Eligible Persons may enroll themselves and their Dependents under the Plan.

To continue reading, go to left column on next page.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Maximum Plan Benefit - the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Plan, or any other Plan of the Plan Sponsor. When the Maximum Plan Benefit applies, it is described in (Section 1: What's Covered--Benefits).

Medicare - Parts A, B, and C of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Plan.

To continue reading, go to right column on this page.

Out-of-Pocket Maximum - the maximum amount you pay out-of-pocket every calendar year. Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available by an optional Rider, such as prescription drugs.
- Copayments for Covered Health Services, such as Inpatient Hospital and Emergency Room.
- The Annual Deductible.
- Charges that exceed Eligible Expenses.
- Any amounts applied towards meeting your Annual Deductible.

Even when the Out-of-Pocket Maximum has been reached, the following will not be paid at 100%:

- Any charges for non-Covered Health Services.
- Charges that exceed Eligible Expenses.
- Copayments for Covered Health Services, such as Inpatient Hospital and Emergency Room.

Physician - any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that

To continue reading, go to left column on next page.

Benefits for services from that provider are available to you under the Plan.

Plan – Medical Plan for Retired Employees Eligible for Medicare sponsored by the Hanford Employee Welfare Trust.

Plan Administrator - is the Hanford Employee Welfare Trust or its designee as that term is defined under ERISA.

Plan Sponsor - Hanford Employee Welfare Trust. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- For handicapped children, any complications associated with Pregnancy.

Retiree - an Eligible Person who is properly enrolled under the Plan.

Rider - any attached written description of additional Covered Health Services not described in this SPD. Riders are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

To continue reading, go to right column on this page.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Spinal Treatment - detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse – the legal spouse of an Eligible Person.

Substance Abuse Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Surviving Spouse – the Eligible Spouse who survives the death of the Eligible Person.

Unproven Services - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

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- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and the Claims Administrator may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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Attachments

Attachment I

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Attachment II

Summary Plan Description

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Attachment I

Statement of Rights under the Newborns' and Mothers' Health Protection Act

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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Attachment II

Summary Plan Description

Name of Plan: Hanford Employee Welfare Trust

Name of Employers sponsoring the Plan: A complete list of Employers sponsoring the Plan may be obtained by Participants and Beneficiaries upon written request to the Plan Administrator and is available for examination by Participants and Beneficiaries as required by Department of Labor Regulation Sections 2520.104b-1 and 2520.104b-30.

The following are Medicare Plan Sponsors as of January 1, 2007:

Advanced Technologies and Laboratories International, Inc. – Eligible Class: HAMTC represented and incumbent salaried exempt and non-exempt

American Electric, Inc. – Eligible Class: HAMTC represented

CH2M HILL Hanford Group, Inc. (CHG) – Eligible Class: HAMTC represented and salaried exempt and non-exempt

Duratek Federal Services of Hanford, Inc. – Eligible Class: Salaried exempt and non-exempt

Eberline Services Hanford, Inc. – Eligible Class: HAMTC represented and salaried exempt and non-exempt

Energy Northwest - Eligible Class: HAMTC represented

To continue reading, go to right column on this page.

Fluor Hanford, Inc. (FH) – Eligible Class: HAMTC represented, HGU represented, OPEIU represented and salaried exempt and non-exempt

Johnson Controls, Inc. – Eligible Class: HAMTC represented

Numatec Hanford Corporation (NHC) – Eligible Class: Salaried exempt and non-exempt

Parsons Hanford Fabricators, Inc. – Eligible Class: HAMTC represented

Washington Closure LLC – Eligible Class: HAMTC represented and salaried exempt and non-exempt

Incumbent Employees are identified in the applicable prime contract with the Department of Energy or applicable subcontract agreement.

Name, Address and Telephone Number of Plan Administrator and Named Fiduciary:

Hanford Employee Welfare Trust c/o Fluor Hanford, Inc.,
P. O. Box 1000,
MSIN H2-23Richland, WA 99352, (
509) 376-7156

The Plan Administrator retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Administrator has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Employer Identification Number (EIN): 33-0691003

IRS Plan Number: 551

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Effective Date of Plan: January 1, 2007

Type of Plan: Group health care coverage plan

Name, Business, Address, and Business Telephone Number of Trustees:

Trustees of the Hanford Employee Welfare Trust,
c/o Fluor Hanford, Inc.,
P. O. Box 1000, MSIN H2-23
Richland, WA 99352(509) 376-7156

Claims Administrator: The company which provides certain administrative services for the Plan.

UnitedHealthcare Insurance Company,
P.O. Box 150,
450 Columbus Boulevard, Hartford, CT 06115-0450

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan.

Type of Administration of the Plan: The Plan Administrator provides certain administrative services in connection with its Plan. The Plan Administrator may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of Benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. The Plan Administrator also has selected a Provider Network established by UnitedHealthcare

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Insurance Company. The named fiduciary of Plan is Hanford Employee Welfare Trust, the Plan Administrator.

Person designated as agent for service of legal process: The name and address of the Agent for Service of Legal Process for the Plan is:

Ralph L. Hawkins
Davis Wright Tremaine LLP
1501 Fourth Avenue
2600 Century Square
Seattle, Washington 98101 – 1688

(206) 628-3150

Legal process may also be served upon a Plan Trustee or the Plan Administrator.

Source of contributions under the Plan: The sources of the contributions to the Plan are Employer and Employee contributions.

Method of calculating amount of contribution: Employee required contributions are determined by each Plan Sponsor. A schedule of such required contributions will be made available to eligible persons.

The Hanford Employee Welfare Trust is a funding medium through which benefits are provided.

Date of the end of the year for purposes of maintaining Plan's fiscal records: Plan year shall be a twelve month period ending December 31.

Determinations of Qualified Medical Child Support Orders: The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

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Reservation of Rights to Amend or Terminate: Although each Plan Sponsor currently intends to continue the Benefits provided by this Plan, each Plan Sponsor reserves the right, at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add Benefits or terminate this Plan or this Summary Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. Any change or Amendment to or termination of the Plan, its Benefits or its terms and condition, in whole or in part, shall be made solely in a written Amendment (in the case of a change or Amendment) or in a written resolution (in the case of termination), whether prospective or retroactive, to the Plan. The Amendment or resolution is effective only when approved by the body or person to whom such authority is formally granted by the terms of the Plan. No person or entity has any authority to make any oral changes or Amendments to the Plan.

Additional Information: Benefits under the Plan are furnished in accordance with the Plan Description issued by the Plan Administrator, including this Summary Plan Description.

Participant's rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the procedures to be followed in regard to denied claims or other complaints relating to the Plan are set forth in the body of this Summary Plan Description.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

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

To continue reading, go to right column on this page.

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another group health Plan. You should be provided a certificate of creditable coverage in writing, 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

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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. You may request a certificate of creditable coverage by contacting the Plan Administrator. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or

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in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court after all required reviews of your claim have been completed. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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The benefits administered by UnitedHealthcare are described on pages –1 - 67

Please contact UnitedHealthcare with any questions on these health benefits.

The ***Pharmacy Benefit Program*** described on pages –71 – 76, relate to coverage administered by Express Scripts, Inc.

Please contact Express Scripts with respect to these pharmacy benefits.

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Prescription Drugs

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Prescription Drug Benefits

Provided with the "OPTIONS PPO"
Medical Plan for Medicare-Eligible Retirees
and Dependents

Administered by Express Scripts, Inc.

Benefits in effect on January 1, 2007

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PRESCRIPTION DRUGS

A separate Pharmacy Benefit Program covers prescription drugs. This program is administered by Express Scripts. UnitedHealthcare does not administer the prescription drug portion of this retiree medical plan. There are two ways you can purchase prescription drugs, from a participating **retail** pharmacy or by using **mail order**. This Prescription Program in effect as of January 1, 2007, and administered by Express Scripts, is briefly described below. More details of the program are available directly from Express Scripts.

Express Scripts, Inc. "Step Therapy" Prescription Program:

A new program called "Step Therapy" applies to all retirees receiving pharmacy benefits through Express Scripts, Inc. The program was effective on January 1, 2007, and is intended to make prescription drugs more affordable for most members and help the HEWT control the rising cost of prescription drugs. Step Therapy is a prescription management program for participants with new conditions that require maintenance medication. In Step Therapy, the covered drugs you take are organized in a series of "steps," with your doctor approving and writing your prescriptions.

- The program usually starts with generic drugs as the "first step." Rigorously tested and approved by the U.S. Food & Drug Administration (FDA), the generics covered by the program have been proven to be effective in treating many medical conditions. This first step allows you to begin or continue treatment with safe, effective prescription drugs that are also affordable. Your co-payment is usually the lowest with a first-step drug.

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- More expensive brand-name drugs are usually covered in the "second step."

- Your doctor is consulted, approving and writing your prescriptions based on the list of Step Therapy drugs covered by the program. For instance, your doctor must write your new prescription when you change from a second-step drug to a first-step one.

Please refer to the materials which were recently distributed for additional information on the "Step Therapy" Prescription Program or, if you have questions, contact Express Scripts Mail Service Pharmacy directly at 1-800-796-7518.

If you are enrolled in Medicare Part D for medications please contact Beth Bremner Brown at 509-372-8284.

Your Share of the Cost (Co-payments)

Both the mail and the retail programs have three-tier co-payment structures. When you purchase a prescription, your cost will be the required co-payment (or you can pay the actual cost of the drug, if it is less than the applicable co-payment amount). The co-payment depends on the category of the drug, and whether it is from retail or mail order.

The three categories, or tiers, are:

Generic: Drugs in which the patent has expired, allowing other manufacturers to produce and distribute the product under a generic name. Generics are essentially a chemical copy of their brand-name equivalents. The color or shape may be different, but the active ingredients must be the same for both.

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Preferred Brand Name: A drug with a trade name under which the product advertised and sold, and is protected by patents so that it can only be produced by one manufacturer for 7 years.

Non-Preferred Brand Name: A brand medication that has been reviewed by a Pharmacy and Therapeutics committee (physicians and pharmacists) who determine that an alternative drug that is clinically equivalent and more cost effective is available.

Your druggist can determine the category of a drug, or you can contact Express Scripts by calling their toll-free Customer Service line (**1-800-796-7518),** or via the internet at **www.express-scripts.com.**

The following features are applicable to Retail AND to Mail Order:

- There is an annual **maximum out-of-pocket limit of $1,500** per member. Both mail order and retail co-payment amounts apply in the calculation.
- There is **NO Deductible.**
- Co-payment amounts for both mail order and retail prescriptions are in effect as of January 1, 2007. These are subject to change.
- There are no replacement prescriptions allowable under the Plan.
- Quantity limits may apply to some drugs. These are determined by the manufacturer and are subject to change.

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Most prescription drugs are available to you under the Plan. They will be dispensed as written by the physician. However, you will pay more out-of-pocket if you request a brand-name drug when the prescription is written for a generic drug.

Exclusions

-Drugs that are NOT covered by the Plan include, but are not limited to, the following:

- multiple vitamins (including vitamins with fluoride)
- prenatal vitamins
- appetite suppressants
- injectable drugs (Certain injectable drugs are covered. Contact Express Scripts for specific information)
- medications for cosmetic purposes (e.g. Rogaine)
- medications with no FDA indications (e.g. yohimbine)
- nystatin oral powder
- oral contraceptives
- injectable contraceptives (e.g. Depo-Provera)
- diaphragms
- progesterone products (including compounded forms)

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- over-the-counter (OTC) medications or products equivalent to OTC medications
- vitamin B12
- smoking deterrents
- anorexiants or other drugs used for weight control
- DESI drugs (drugs determined by the Food and Drug Administration to lack substantial evidence of effectiveness)
- drugs labeled "Caution – limited by federal law to investigational use" or experimental drugs
- therapeutic devices or appliances, support garments and other non-medical substances
- immunizing agents, biologicals, blood and blood plasma
- Accutane (Isotretinoin)
- all forms of Retin A
- all "over-the-counter" drugs not needing a prescription.

Prescription Drug Review

Some prescription drugs require a "prescription drug review" or prior authorization before they may be covered by the Plan. If your pharmacist tells you that your prescription drug requires prior

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authorization, ask your pharmacist or your doctor to call Express Scripts.

Customer Service Center

The Express Scripts Customer Service Call Center is available 24 hours a day, 365 days a year to help you locate a participating pharmacy or to help you better understand and use your program. To reach the call center, call toll-free: **1-800-796-7518.** (TDD for hearing impaired: 1-800-899-2114, or 1-612-797- 4566).

In an emergency, a pharmacist can be reached 24 hours a day at 1-800-626-6080.

RETAIL PRESCRIPTION PROGRAM

Express Scripts offers retail prescription coverage at over 43,000 participating pharmacies nationwide. Check with your pharmacy to see if they are an Express Scripts participant, or contact Express Scripts Customer Service for help in locating a participating pharmacy in your area.

Your Cost

The Retail Prescription Program allows you to purchase up to a 34-day supply for a co-payment. Quantity limits may apply based on type of medication prescribed.

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The following co-payments apply to prescriptions purchased from a participating retail pharmacy:

Category	Co-Payment
Generic Drugs	$7.00
Preferred Brand-Name	$25.00
Non-Preferred Brand-Name	$40.00

Purchasing Prescriptions

At a Participating Retail Pharmacy -

When you purchase a prescription under this Plan, you simply present your identification card (provided to you by Express Scripts)

and co-payment amount. No claim forms are required after co-payment is made.

At a Retail Pharmacy that is not participating with Express Scripts -

You can also purchase a drug at a non-participating pharmacy. You should pay for the prescription, then submit a claim for reimbursement from Express Scripts.

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However, if you do, your reimbursement will be based on the Express Scripts in-network contracted rate for that drug, less the required co-payment.

You will have to pay the difference between the price charged by the non-network pharmacy and the Express Scripts contracted rate in addition to the applicable co-payments.

For non-network retail purchases, complete an Express Scripts claim form and submit your claim and receipts to:

Express Scripts, Inc.
P.O. Box 390873
Bloomington, MN 55439

Claim forms for out-of-network purchases can be requested from Express Scripts web site, www.express-scripts.com, or by calling customer service at **1-800-796-7518.**

MAIL ORDER DRUG PROGRAM

Another option for obtaining prescriptions is the Mail Order Drug Program, which allows you to purchase up to a 90-day supply of most prescription drugs for a single co-payment. The mail order pharmacy program is also administered by Express Scripts. The Mail Order program works best for drugs that you take on a long-term basis ("maintenance drugs."). Certain drugs are not available by mail order. Contact Express Scripts Customer Service for more information.

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Your Cost

The following co-payments apply to prescriptions purchased from the Express Scripts Mail Order program.

Category	Co-Payment
Generic	$14.00
Preferred Brand-Name	$50.00
Non-Preferred Brand-Name	$80.00

Purchasing Mail-Order Prescriptions

Ask your physician to prescribe needed medication for up to a 90-day supply, plus refills. If you, or your eligible Dependents, are presently taking medication, ask your doctor for a new prescription. Complete the patient profile questionnaire with your first order. Answer all questions and be sure to include your Social Security number on the form.

You can contact Express Scripts for the necessary mail order form and other information for the necessary form and for other information.

Send the completed mail order form along with your prescription written for 90 days and your applicable co-payment. You can submit multiple prescriptions in one envelope; just be sure to include a co-payment for each prescription. Contact Customer Service to determine which category your prescription is: generic, preferred brand-name or non-preferred brand-name.

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Your prescriptions will be filled and returned to you at the address you have specified on your order form. If you need to change the address, please call the toll-free "800" number listed on your order form, or you can change the address on the form itself.

Most prescription orders take 14 days to be filled and returned to you unless there are mail delays. If you need a supply of medication while waiting for your mail order prescription, ask you doctor for two prescriptions, so you can get a small supply of medication from your local pharmacy while awaiting your Express Scripts prescription.

Once your Express Scripts Mail Order facility has processed your first prescription, you can order approved refills either by mail or on the internet at www.express-scripts.com.

Any time you have questions on your medication(s), you can call the Customer Service Department and talk to a pharmacist.

Their toll-free number is: 1-800-796-7518.

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CLAIM AND APPEAL PROCEDURE

If you are not satisfied with the disposition of your claim for benefits under the Pharmacy Benefit Program, you have the right to appeal to the Plan Administrator. Your appeal should be filed with the Plan Administrator within 60 days of the denial of your claim by Express Scripts. For the Appeal Procedure see the Plan Document, Summary Plan Description and Administrative Information, Hanford Retiree Welfare Benefit Plans (Administrative Wrapper). A copy of the Administrative Wrapper may be obtained without charge by contacting Fluor Hanford Benefits Administration.

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