ALL ABOARD!

Welcome to the Wabash Memorial Hospital Association where railroaders have had a say in designing their own health benefits since 1884. We are proud to be in our third century of serving railroaders and look forward to providing quality service to our members for years to come.

Originating in 1884 as the Hospital Department of the Wabash, St. Louis & Pacific Railway, Wabash Memorial Hospital Association is a non-profit Health and Welfare Trust Association, operating under Public Law 93-406 as an employer sponsored ERISA Plan through the Department of Labor.

Contact Information

Wabash Memorial Hospital Association
PO Box 1340 - 1501 North Water Street
Decatur, Illinois 62526
www.wabashcannonball.org
Text Relay Link For Hearing Impaired On Website

Benefit Coverage, Membership and Eligibility,
Claims Inquiries, Provider Information
Local Number - (217) 429-5246
Toll Free Number - (888) 800-9161
Fax Number - (217) 429-1222

Decatur Wabash Outpatient Clinic
Local Number - (217) 425-9642
Toll Free Number - (888) 419-6435
Clinic Fax Number - (217) 425-9660

Board of Managers - 2016

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Sheet Metal, Air, Rail and Transportation Workers

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Brotherhood of Railroad Signalmen

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International Association of Machinists & Aerospace Workers

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National Conference of Firemen and Oilers

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Retiree Representative (Alternate)

Tim Southerland
Affiliated System Federation Brotherhood of Maintenance of Way

Tracey Sumpter
Brotherhood of Railroad Carmen

Wabash Administration
Tamara Bivins, Administrator

MEMBER RIGHTS AND RESPONSIBILITIES

Your Right To Be Treated With Fairness and Respect You have the right to be treated with respect and fairness at all times. Wabash must obey laws against discrimination that protect you from unfair treatment. Neither Wabash or your employer, union or any person can discriminate against you in any way and prevent you from obtaining welfare benefits or exercising your rights under ERISA because of your race or color, age, religion, national origin, or any mental or physical disability you may have.

Receive Information About The Plan And Benefits Examine, without charge, at the Plan Administrator's office documents governing the plan, 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 Administration.

Upon written request to the plan administrator, you may obtain copies of documents governing the operation of the plan, 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. You may receive a summary of the plan's annual financial report. This summary annual report is made available to participants on the website at www.wabashcannonball.org.

Your Right To The Privacy Of Your Medical Records There are federal and state laws that protect the privacy of your medical records and personal health information (PHI). We keep your personal health information private as protected under these laws. Any personal information that you give us when you enroll in this plan is protected. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. Complete the "Release of Information" form to allow others access to your personal health information. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care. Notice of Privacy Practices and Release of Information form and policy is available to participants at www.wabashcannonball.org.

Your Right To Know Your Treatment Choices And Participate In Decisions About Your Health Care You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment choices that are recommended for your condition, no matter what they cost or whether they are covered by Medicare. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments. You have the right to refuse treatment. This includes the right to leave a hospital or other medical

facility, even if your doctor advises you not to leave. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

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.

Continuation of Group Health Plan Coverage (COBRA) Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as the 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 or the rules governing your COBRA continuation rights.

Creditable Coverage Certificate of Insurance The Health Insurance Portability and Accountability Act (HIPAA) requires that medical plans grant credit for prior coverage called creditable coverage. Upon termination, Wabash will issue you a certificate to provide you with evidence of your coverage in the Wabash medical plan at your request.

Information 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. Procedures to request, review and appeal a plan decision are included in the handbook and on the website at www.wabashcannonball.org.

Voting Rights Membership does not confer any voting right upon any person referred to as a "member". Wabash by-laws confer the right to vote on all Wabash business to the Board of Managers.

Know Your Coverage – Be familiar with your benefit coverage and rules you must follow to get care.

Member Etiquette A member's responsibility includes acting in a way that supports the care given to other patients and promoting the smooth operation of your doctor's office, hospital or other office.

Participate In Your Healthcare Remember to give your doctor and other providers the information they need to care for you and follow the treatment plans and instructions that you and your doctors agree upon.

Update your Contact Information Members must notify Wabash of any change of address or eligibility status.

Contact Us Call Member Services at 888-800-9161 if you have any questions, concerns, problems or suggestions.

INTRODUCTION

Purpose of Plan The Plan exists to provide healthcare benefits for employees and retirees (and their dependents) of the Wabash, St. Louis and Pacific Railroad Company. Such benefits will be provided in accordance with the rules, regulations and bylaws of the Association as approved by the Board of Managers.

Future of Plan Assets of Wabash Memorial Hospital Association are held in Trust by the Hickory Point Bank. While Wabash intends to continue the Plan indefinitely, it reserves the right to terminate or amend the Plan for any reason. If Wabash terminates or amends the Plan, benefits under the Plan would cease or change. Any remaining assets would be subject to disposition in accordance with Department of Labor requirements.

Wabash may also increase the required employee or retiree contributions at any time. Similarly, Norfolk Southern Corporation can take any such actions with respect to its employees. Every effort will be made to provide Plan participants with reasonable notice of any such change.

Health Care Prepayment Plan (HCPP) Wabash is under contract with the Center for Medicare and Medicaid Services (CMS) that administers the Medicare Health Plan as a Health Care Prepayment Plan (HCPP). An HCPP is an organization that provides or arranges for some or all of Part B Medicare benefits on a prepayment basis. All Wabash Medicare Plan participants are automatically enrolled in our HCPP. Payment for Medicare Part A coverage for hospital care and related services is made on a fee-for-service basis.

As an HCPP, Wabash is authorized to pay both your primary and secondary Part B claims at one time to participating physicians and other Part B providers. Wabash can make the complete Medicare payment to the provider for the following services provided by a physician:

a. Outpatient visits and office charges
b. Hospital Visits
c. Inpatient and outpatient consultations
d. Surgical procedures
e. X-rays and other outpatient services

Medicare Participating Provider – Wabash encourages members to receive healthcare from physicians and healthcare professionals who accept Medicare-approved amounts as payment in full for their services.

Board Disclaimer Wabash acknowledges that errors and/or omissions could occur in the presentation of this document. The Board of Managers, through its Administrator, reserves the right to interpret this Handbook and its Rules and Regulations according to its original intent

and not how it may appear through an error. They also reserve the right to amend this document as may be necessary from time to time.

Membership Eligibility

Eligibility – Wabash membership in a Medicare supplemental plan is available to any current Wabash member and the following Medicare eligible relatives:

a. Current spouse or widow(er) of anyone currently or previously employed by the railroad or Wabash for at least five years
b. Child, parent and parent-in-law of a Wabash member, provided that the member has been enrolled in Wabash no less than five years

Part D Participation – Participation in any Wabash prescription drug program does not preclude you from enrolling in a commercial Part D drug plan independently. Members may continue in a Medicare supplemental plan with Wabash.

Enrollment – Current Wabash members may convert to one of our Medicare Supplemental Plans at the time of first eligibility (normally at age 65). Members are automatically part of our HCPP upon enrollment. The participant must inform Wabash of their desire to become a member. Wabash will send the applicant an enrollment form to complete, sign and return with proof of Medicare enrollment. Wabash electronically sends your information to CMS for approval. Once we are notified of approval, your secondary coverage begins under Wabash. The effective date of enrollment will be indicated on the confirmation letter you will receive from Wabash.

Disenrollment – Disenrollment in the Plan may be voluntary or involuntary

A. **Voluntary Disenrollment** –A member may voluntarily terminate their membership by providing written notification to Wabash no later than the 15th day prior to the 1st day of the month they want benefit coverage to end. The member will be responsible for all dues owed prior to the effective date of the termination.

   Benefit coverage is extended to the last day of the month for which dues have been paid. If membership is terminated due to a member's death dues are owed and benefits are extended for the month in which death occurred. Dues paid for any months following the member's date of death will be refunded to the member's estate.

B. **Involuntary Disenrollment** – Original Part A and Part B is not affected by your disenrollment from Wabash. You may be involuntarily disenrolled from Wabash for any of the following reasons:
   1. Enrollment in Medicare Part A or B ends
   2. Failure to make the required Wabash dues payment
   3. Misrepresenting membership application data
   4. Not abiding by regulations of Wabash and HCPP

5. Improper use of your Medicare or Wabash insurance card
6. Inappropriate or disruptive behavior to our staff or other members
7. Upon death of a member, membership will terminate at the end of the month in which the member expired. Upon receipt of written proof of death, any dues paid in advance will be refunded to the estate.

Reinstatement

Individuals rejoining Wabash will have a 90-day waiting period from the date application for reinstatement and payment of first month's dues is received by Wabash before coverage will be in effect. In addition, pre-existing illnesses / conditions will not be covered for 12 months from the reinstatement effective date. This rule will not apply to Railway employees who have resigned or been dismissed from the Railway and subsequently rehired.

Payment of Dues

Payment is due on the first of the month to receive benefit coverage for that month. Dues must be received within fifteen (15) days of the due date. Members are encouraged to utilize automatic withdrawal of dues from their bank account to pay dues.

Failure to remit dues within the fifteen (15) day time limit will result in suspension of membership and eligibility to participate in any benefit plan associated with Wabash until all dues owed to Wabash are paid in full. If dues payment is not received with the fifteen (15) day period a six (6) month waiting period will be enforced before reinstatement of membership and provision of benefits in addition to an exclusion period of twelve (12) months for any pre-existing illness or condition as of reinstatement.
Failure to remit dues will result in termination of membership and eligibility to participate in any benefit plan associated with Wabash. The member will be responsible for all dues owed prior to the effective date of the termination plus cost of collection, including attorney fees incurred by Wabash.

Wabash shall have the right to waive, in whole or in part, the suspension or termination of membership and / or exclusion period for good cause by the member. The waiver, if any, shall be solely and exclusively within the discretion of Wabash.

Exclusions

The following is a general list of services, supplies, equipment and benefits that are excluded from benefit coverage unless specifically provided by your plan. Members should refer to their individual plan coverage for actual terms and conditions that apply or contact Customer Service prior to receiving services.

Abortion – Except as necessary to protect life of the mother

Acupuncture

Against Medical Advice (AMA) Non-Compliance – A member may opt not to comply with recommended treatment. In such cases, the plan will not assume any further liability for services, supplies, medication and testing for a particular condition unless the member later decides to follow prescribed treatment under the care of the ordering physician and subject to the terms of the Member's coverage.

Air Ambulance

Another Payor – The cost of services, which are the responsibility of a payor other than the plan including, but not limited to:

- Group, blanket or franchise insurance coverage
- Labor management trustee plan, Union Health and Welfare Plan, union or labor management welfare plan or employer organization plan
- Coverage under a governmental program
- Coverage required by statute such as worker's compensation, occupational disease or employer liability laws
- Medicare supplemental plan
- Individual automobile or homeowner insurance coverage based upon personal injury protection and medical payment coverage
- Individual automobile insurance coverage based upon the principles of No Fault Coverage

Biofeedback

Breast Augmentation, Mastopexy, reduction or implant removal – Procedures requested for cosmetic purposes, except as required by law regarding breast reconstruction following mastectomy.

Contraceptive Services, Prescription drugs and devices

Cosmetic or reconstruction Services - Unless medically necessary or follows trauma which causes anatomic functional impairment or is needed to correct a congenital disease or anomaly which has resulted in a functional defect

Dentistry/Oral Surgery – Dental and oral surgery and care unless result of accidental injury or medically necessary and not covered under dental plan

Drug Testing – Drug screen testing except as may be required prior to admission to a substance abuse program or in the emergency room.

Durable Medical Equipment (DME) - The rental, purchase, repair and replacement of durable medical equipment

Educational – Educational, tutorial, vocational evaluation, testing, screening and any other services and supplies

Enteral or Parenteral Feeding – Supplements and/or supplies

Exercise and Fitness Equipment and Services – Including, but not limited to bicycles, treadmills, stair climbers, and pool or health club memberships

Expenses Exceeding Plan Allowable

Experimental or Investigational – Any drug, device, medical treatment or procedure considered experimental or investigative including clinical trials

Extended Care – Long term care at skilled care facility, sanitarium rest home, nursing home or half way home or custodial care

Eye and Vision

- Routine eye examination, services, therapy and supplies
- Diagnosis and treatment of refractions
- Surgery to correct vision including, but not limited to, radial keratotomy, PRK and LASIK
- Eyeglasses or contact lenses
- Corrective lenses following cataract surgery

Foot Care – Routine foot care including, but not limited to, removal of corns or calluses, trimming of nails

Genetic Testing and Counseling

Hypnotherapy

Illegal Occupational/Crime – Expenses incurred for an illness or injury suffered in connection with the commitment of or intent to commit a felony

Infertility / fertility – All services, tests, medications and treatments in connection with the diagnosis or treatment of infertility including, but not limited to, in vitro fertilization, reversal of sterilization, surrogate services and adoption

Maximum Benefit – Amounts in excess of a benefit limit

Medically Necessary - Any services, supplies, treatments or procedures not specifically listed as a Covered Service and any other services, supplies, treatment or procedures determined not to be medically necessary

Medical Equipment and Supplies – Any disposable or convenience medical equipment, appliances, devices and or/supplies

Mental Health and Substance Abuse Services – The following mental health and substance abuse services are excluded from coverage:

- Not medical necessary treatments
- Non-medical ancillary services including, but not limited to, vocational rehabilitation services, employment counseling, expressive therapies and health education
- Psychological examinations, testing or treatment for the purpose of obtaining or maintaining employment or insurance, or related to judicial or administrative proceedings
- Court ordered examinations or care unless medically necessary
- Psychiatric treatment for sexual dysfunction or sexual therapy
- Psychoanalysis to complete degree or residency requirements
- Light therapy
- Psychological testing for educational purposes
- Gender identity disorders including sex change operations

Motorized or Power Operated Vehicles – Including, but not limited to, any adaptations to motorized or power operated vehicles and/or chair lifts

Other than Plan responsibility – Including, but not limited to, employer provided benefits for dental and vision, home or auto insurance of responsible party, worker's compensation, government or employer liability. Neither Wabash, nor the Plan is responsible for, and neither will provide coverage for treatment on account of, any illness, disease, injury, harm, damage, loss, cost, expense and/or fee for which some potentially responsible third party possesses, or is claimed by the Claimant to possess, legal liability or responsibility therefore.

Personal Convenience Item – Including, but not limited to, telephones, televisions, extra meal trays and personal hygiene items, ice bags, chairs, air conditioners, water purifiers, humidifiers, dehumidifiers, saunas, swimming pools or hot tubs and adaptions to the home.

Pharmaceuticals

- Outpatient prescription drugs and supplies unless provided by plan
- Outpatient self-administered drugs
- Pharmacy consultations
- Medication and supplies that can be purchased over the counter
- Medication without FDA approval for recommended treatment
- Medication and supplies not requiring physician prescription
- Nutritional Supplements
- Co-payments

Postage, Shipping and Handling Expenses or Sales Tax

Private Duty Nursing

Provider not prescribed – Services or supplies not prescribed, performed or directed by a provider licensed or certified to do so

Provider clerical charges – This includes, but is not limited to, charges for no show appointments, telephone calls, completion of forms, transfer of medical records, the cost of copying medical records, or the generation of correspondence to other parties.

Timely Filing

- Services incurred before the member's effective date
- Services incurred after the member's coverage terminated
- Claims not filed within 15 months from the date of service

Transplant Services

Travel and Transportation – Except for medically necessary emergent transport and ambulance services approved and authorized by the Plan

Treatment received outside the USA

Usual, Customary and Reasonable (UCR) – Wabash will not pay charges for amounts billed by providers that are determined to be in excess of what is usual and customary for that service or treatment.

Claims

Reliance On Documents And Information - Information required by the Plan Administrator may be provided in any form or document that the Plan Administrator considers acceptable The Plan Administrator relies on the information provided when evaluating coverage and benefits under the plan. All such information must be accurate, truthful and complete. The Plan Administrator is entitled to conclusively rely upon, and will be protected for any action taken in good faith in relying upon, any information provided to the Plan Administrator. In addition, any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result in the denial of the claim, cancellation or rescission of coverage, or any other legal remedy available to the plan.

Coordination of Benefits - The coordination of benefits provision applies when the allowable charges incurred on behalf of a member are also covered by another payor. The plan is not intended to pay expenses for which another payor is liable. All benefits payable by the plan shall be reduced by any amount the member is entitled to claim for use or benefit under coverage of another payor.

Maximum Combined Benefit - The combined benefits paid by this plan and all other payors shall not exceed 100% of the allowable charges incurred. The plan will not provide duplication of benefits. In the event the plan pays amounts in excess of the maximum amount payable by the plan under this section the plan shall have the right to recover payment to the extent of the excess from any person or entity to or for payment was made.

Overpayment of Benefits – In the event of any overpayment of benefits by this Plan, this Plan will have the right to recover the overpayment. If a member is paid a benefit greater than allowed in accordance with the provisions of this Plan, the member will be requested to refund the overpayment. If the refund is not received from the member, the amount of the overpayment will be deducted from future benefits. Similarly, if payment is made on the behalf of a member to a hospital, physician, or other provider of health care, and the payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider.

Order of Payment –Payment is determined in the following order:
Primary Plan coverage -The primary plan assuming first payor status will determine benefits first without regard to benefits provided under any other plan. The plan determines primary as follows

1. The primary plan with no coordination of benefits provision will be first payor.
2. If the first payor is not determined by 1.above, the primary plan covering the person as an active employee will be first payor.
3. If the first payor is not determined by 1.or 2.above, the plan that has covered the member for the longer period of time will be first payor.

Secondary Plan coverage -When the Plan is the secondary payor, it will pay, subject to all plan provisions, including exclusions and maximums, the balance of remaining allowable charges unpaid by the primary payor not to exceed the liability if the primary payor was the Plan. Auto insurance coverage – When a member expense is eligible for coverage under the plan and under a group or individual fault or no fault auto insurance plan, the auto insurance carrier will be primary.

Claim Filing-The Coordination of benefits provision applies whether or not a claim is filed with other payors. It is the member's responsibility to provide the Plan with supporting documentation of payment made by the other payor within the Plan's claim filing deadline in order to receive reimbursement under the plan.

Other Payors – Other payors may include, but are not limited to:

Group, blanket or franchise insurance coverage
Labor management trustee plan, Union Health and Welfare Plan, union or labor management welfare plan or employer organization plan
Coverage under a governmental program
Coverage required or provided by statute
Medicare supplemental plan
Individual automobile or homeowner insurance coverage based upon personal injury protection and medical payment coverage
Individual automobile insurance coverage based upon the principles of No Fault coverage

Assignment of Benefits - All benefits payable by the plan are automatically assigned to the provider of services or supplies, unless evidence of previous payment is submitted with the claim. Payments made in accordance with an assignment are made in good faith and release Wabash's obligation to the extent of the payment. Payments will also be made in accordance with any assignment of right required by a state Medicaid plan and/or a Federal Medicare Plan.

Filing Procedures - Present your Wabash insurance card and your Medicare card to your provider at each visit. Medicare claims should be filed electronically. If unable to submit electronically, a copy of the itemized claim and the Explanation of Medicare Benefits will be accepted.

Request that your provider file claims as a Health Care Prepayment Plan (HCPP) provider to receive payment for both primary and secondary benefits directly from Wabash.

Filing Deadline – Wabash must receive all claims and information required for claim processing within fifteen months from the date of service to provide benefit coverage.

SUBROGATION

Other Than Wabash Responsibility

No benefits are payable for conditions covered by services or indemnifications or reimbursement available through any Government agency, or under any Workmen's Compensation or Employer's Liability Law. Neither Wabash, nor the Plan, is responsible for, and neither will provide coverage for treatment on account of, any illness, disease, injury, harm, damage, loss, cost, expense and/or fee for which some potentially responsible third party possesses, or is claimed by the Claimant to possess, legal liability or responsibility therefore.

Lack of Coverage for Treatment Required Due to Actions/Omissions of Person(s) Legally Liable for Injury, Illness or Disease

(a) For all purposes of this section of these General Rules, the following definitions shall apply to the Capitalized terms hereof unless such definition or construction works an absurd result:

1. **"Action"** - shall mean any claim, demand, cause of action, lawsuit (actual or threatened), litigation, proceeding pursuant to any worker's compensation legislation of any state (or similar legislation), proceeding pursuant to any federal statutory liability legislation (including, but not limited to, claims pursuant to the Federal Employers' Liability Act or FELA, 45 U.S.C. §51, et seq., as said Act now exists or may hereafter be amended from time to time), arbitration proceeding, mediation proceeding, or proceeding instituted to collect from any person (or any insurance carrier under any "no fault" provision of any state or where direct actions against insurers are permitted), which recovers, requests, or seeks monies, benefits, compensation or reimbursement for any actual or claimed injury, damage, loss, cost, expense, compensatory damages, consequential damages, or punitive or exemplary damages to, or suffered by, the Claimant (as defined herein), or derived from any injury, damage, loss, cost, or expense of the Claimant (as defined herein). The term "Action" shall exclude therefrom any claim against Wabash (as defined herein).

2. **"Benefits"** - shall mean any and all treatments, medical devices, examinations, therapies, diagnoses, pharmaceuticals, funds, monies, reimbursement, or payment on behalf of the Claimant (as defined herein) to any healthcare provider thereof, or other monies, funds, or things of value provided to, or for the benefit of, the Claimant (as defined herein) by Wabash (as defined herein) as a result of any claim or request by the Claimant (as defined herein) for such benefits arising from, or connected with, the Incident (as defined herein), and also shall include any waiver of any obligation otherwise owing to Wabash (as defined herein) from the Claimant (as defined herein) including, but not limited to, any waiver of payment of dues owed to Wabash (as defined herein) as well as any amount otherwise payable from Claimant's (as defined herein) employer or former employer to Wabash (as defined herein)

3. **"Claimant"** - shall mean the member of Wabash (as defined herein) or beneficiary under the Plan (as defined herein), together with any and all agents, employees, attorneys, advisors, administrators, executors, successors and assigns, and any Person (as defined herein) working for or on behalf of said Claimant (specifically excluding the Wabash (as defined herein)), who seeks or requests, or has obtained, Benefits from Wabash for an injury, damage, claim, allegation, assertion, cost, expense and/or fee caused, or alleged to have been caused, by a Responsible Person.

4. **"ERISA"** - shall mean the Employee Retirement Income Security Act of 1974, as amended, P.L. 93-406, 88 Stat. 829, 29 U.S.C. §§ 1001 et seq., any successor legislation thereto and applicable regulations promulgated thereunder by the United States Department of Labor, a department of the United States of America, and/or the United States Department of the Treasury, a department of the United States of America.

5. **"Incident"** - shall mean that event, occurrence or happening from which the Claimant (as defined herein) has alleged, asserted or claimed (or is alleging, asserting or claiming) that the RP (as defined herein) is liable or responsible to the Claimant (as defined herein) for any injury, illness, disease, harm, damage, claim, cost, expense and/or fee.

6. **"Person"** - shall mean any individual, sole proprietorship, entity, corporation, partnership, association (whether incorporated or unincorporated), trust, limited partnership, limited liability company, limited liability partnership, estate, joint venture, joint stock company, government (or department, agency or other subdivision thereof) or other entity recognized by law.

7. **"Plan"** - shall mean that (or any) welfare benefits plan administered by Wabash (as defined herein) pursuant to ERISA (as defined herein).

8. **"Responsible Person" or "RP"** - shall mean any Person (as defined herein) other than the Claimant (as defined herein) and Wabash (as defined herein), who (or which) is, or is claimed to be, responsible or liable to the Claimant (as defined herein), either directly or indirectly, in any Action (as defined herein), for any injuries, damages, claims, allegations, assertions, costs, expenses and/or fees, and any and all agents, employees, directors, officers, partners, trustees, members, attorneys, advisors, insurers, parent corporations, subsidiaries, administrators, executors, successors and assigns, and any person or entity working for or on behalf of said Person (as defined herein).

9. **"Wabash"** - shall mean Wabash Memorial Hospital Association, an Illinois unincorporated not for profit association, which currently maintains its principal offices at 1501 North Water Street, within the City of Decatur, County of Macon, State of Illinois, and where applicable, its directors, managers, officers, employees, advisors, and successors and assigns. Where appropriate in the context used, the term "Wabash" also shall include the "Plan" (as defined herein).

(b) Neither Wabash, nor the Plan, is responsible for, and neither will provide coverage for treatment on account of, any illness, disease, injury, harm, damage, loss, cost, expense and/or fee for which some RP possesses, or is claimed by the Claimant to possess, legal liability or responsibility therefor. Only to the extent as herein described, may Wabash, in its sole discretion, provide Benefits to, or for the benefit of, a Claimant:

1. As soon as reasonably practicable, the Claimant shall inform Wabash, in writing, of the existence of any Action, describe with reasonable detail the Incident and execute an agreement with Wabash, reasonably acceptable to Wabash's legal counsel, wherein the Claimant agrees to abide by the terms hereof and abide by the terms of said agreement entered into in order to effectuate the terms hereof.

2. Where the Claimant has suffered an illness, disease, injury, harm, damage, loss, cost, expense or fee, for which the Responsible Person possesses liability or responsibility as alleged by the Claimant, and the Claimant has expressly informed Wabash of the RP's liability (or claimed liability) associated therewith, but recovery from said RP is expected to require a period of time while the Claimant has incurred, and/or is incurring, liabilities for treatments, medical devices, examinations, therapies, diagnoses and/or pharmaceuticals associated with the aforementioned illness, disease, injury, harm, damage, loss, cost, expense or fee, Wabash may, in the discretion of Wabash, advance Benefits to, or for the benefit of, the Claimant in accordance with the terms and provisions hereof.

3. The Claimant must be an adult with legal capacity to enter into contracts of the type and nature of the contract described herein, and the Claimant must warrant such capacity and that acceptance by the Claimant of the duties and undertakings described herein and/or within any contract with Wabash executed by the Claimant, is not a breach, violation or default of any duty or obligation owed by the Claimant under any other contract, agreement or lawful undertaking by the Claimant.

4. The Claimant shall reimburse Wabash for all Benefits provided to, or for the benefit of, the Claimant by Wabash, which Benefits arise from, are connected or associated with or are the result of the Incident, which reimbursement shall: (i) be made immediately upon receipt by the Claimant, or the legal right by the Claimant to receive, payment from the RP for any injury, illness, disease, harm, damage, claim, cost, expense and/or fee associated with the Incident, whether the Claimant's receipt, or right to receive such payment arises from judgment, arbitration award, settlement, agreement or otherwise; (ii) be equal to the sum of the value of all Benefits, received from Wabash, by, or for the benefit of, the Claimant, due to, arising from, or connected with, the Incident, without regard to whether such Benefits were provided as a result of a direct injury, loss, damage or harm arising from the Incident or any aggravation(s) thereof; (iii) be made to Wabash without decrease, apportionment, or reduction in any manner (including, but not limited to, a reduction for attorney's fees incurred by the Claimant), or for any reason whatsoever, and the requisite reimbursement to Wabash of the benefits shall be in full for all Benefits described herein.

5. The Claimant shall, in a form and manner reasonably acceptable to Wabash, pledge, grant and assign to Wabash a lien on any right to receive monies, funds, consideration, or things of value and such monies, funds, consideration, or things of value received from (or on behalf of), or to be received from, any RP, which lien shall be in addition to, and shall supplement, any lien provided Wabash by law. Any and all proceeds recovered by the Claimant, or recovered on the Claimant's behalf, from any RP shall be subject to said lien, and the Claimant shall ensure that any RP be provided with notice of the lien created hereby prior to any acceptance of funds, monies, assets or things of value by the Claimant from the RP (or on behalf the RP).

6. Wabash shall be fully and completely subrogated to the Claimant's rights and claim against the RP, which subrogation shall mean that Wabash has the right to recover the full and total amount of Benefits provided to, or for the benefit of, the Claimant as a result of the Incident, which subrogation also shall include any access fee paid to any provider network discounting any medical claim of the Claimant.

7. The Claimant shall fully and completely: (i) cooperate with Wabash in pursuit of any Action and the reimbursement, in full, to Wabash of the Benefits; (ii) provide to Wabash such notices and information as may be reasonably required by Wabash for Wabash to protect its rights and interests hereunder, which notices shall specifically include, but not be limited to, prior notification of any settlement, arbitration hearing, mediation session, or trial between the Claimant and the RP as such may relate to the Incident; (iii) provide to Wabash, upon reasonable request, any and all documents supporting the position of the Claimant in any Action, together with medical records, medical reports, x-rays, or other diagnostic records of the Claimant associated with any injury or claim arising from the Incident; (iv) refrain from taking any action, or permit such action, to impair or prejudice the interests of Wabash as herein described and/or as may be set forth within any agreement between the Claimant and Wabash; and (v) execute any and all authorizations required or requested by Wabash for delivery to the RP in order to authorize and direct said RP to make payment in full to Wabash out of the first funds which are otherwise payable to the Claimant by reason of any claim or cause of action which the Claimant might possess on account of, or in any way related to, the Incident.

8. The Claimant is barred and prohibited from settling, compromising or diminishing any Action without providing notice of said intent to Wabash as provided herein, and, in the event Wabash objects to such proposed settlement or compromise, the Claimant will not settle, compromise or diminish said Action unless, and until, the Claimant makes provision for reimbursement and payment to Wabash, in full, for all Benefits.

9. Except as expressly provided herein, the Claimant shall not cause, nor will the Claimant permit, any settlement, assignment, pledge or transfer of any Action (in whole or in part), any right or interest therein, or any proceeds therefrom, without the express written permission of Wabash, nor will the Claimant authorize any settlement or compromise of any Action, or any right associated therewith, without the express written permission of Wabash.

Further, the Claimant will not provide, or permit, payment to any other person or entity possessing a derivative claim arising from, or associated with, the Incident unless and until Wabash receives full payment and reimbursement for all Benefits.

10. The Claimant shall provide a copy of any Notice from Wabash or agreement with Wabash which relates to the Incident and/or the rights of Wabash hereunder to any and all attorneys representing the Claimant in any Action, and will provide further a copy thereof to any Responsible Person, as well as any insurer and/or attorney of any Responsible Person (as such may be known to the Claimant).

11. In the event that the Claimant fails or refuses, within a reasonable period of time, to institute an Action, the Claimant hereby provides, grants, and assigns to Wabash, the right to bring any Action or to sue to recover any Benefits, and hereby authorizes Wabash to utilize the name of the Claimant in any such action. Notwithstanding anything to the contrary herein, the Claimant further agrees to provide a written assignment of any claim held by the Claimant (which claim arises from or is associated with the Action) to Wabash upon written request from Wabash to do so.

Nothing contained herein shall constitute, or be interpreted or construed to constitute a duty or obligation of Wabash to pursue any Action or prosecute any claim, and Wabash shall not owe to the Claimant (or any other Person) any duty or obligation to protect any interest which the Claimant (or any other Person) might possess, or claim to possess, against the RP or any other Person. Moreover, Wabash shall have no duty or obligation to resolve any such Action (or claim) for the benefit of the Claimant, and Wabash may settle or compromise any such Action for such amount, and on such conditions and terms, as deemed proper and appropriate by Wabash in its sole and exclusive discretion without regard to any interest(s) of the Claimant in such proceedings or claim.

The Claimant may preclude Wabash from pursuing any right or action herein described by satisfying, in full, the reimbursement to Wabash for all Benefits provided to, or for the benefit of, the Claimant and arising from or associated with the Incident.

12. The Claimant hereby irrevocably appoints Wabash (and any of Wabash's officers, employees or agents designated by Wabash), with full power of substitution by Wabash, as the Claimant's true and lawful agent and attorney with full irrevocable power and authority in the place and stead of the Claimant and in the name of the Claimant or in Wabash's own name, from time to time in Wabash's discretion, for the purpose of carrying out the terms and provisions hereof, to take any and all appropriate action and to execute any and all documents and instruments which may be reasonably necessary or desirable to accomplish the purposes here. The Claimant hereby ratifies all that said agent(s) or attorney(s) shall lawfully do or cause to be done by virtue hereof. This power of attorney is a power coupled with an interest and shall be irrevocable. Any failure by Wabash to give the Claimant prior notice of actions taken by Wabash hereunder shall not affect the validity or enforceability of any such actions, nor shall Wabash incur any liability or penalties for such failure. The powers conferred on Wabash

hereunder are solely to protect the interests of Wabash in its rights of reimbursement from any proceeds of any Action and shall not impose any duty upon Wabash to exercise any such powers.

13. The Claimant shall (and shall execute an agreement to provide that the Claimant shall): (i) defend, indemnify, reimburse and hold harmless Wabash and its respective managers, directors, officers, attorneys, employees, agents, insurers and representatives (hereinafter in this Section referred to individually and collectively as the "Indemnitees") from any and all liabilities, obligations, losses, damages, penalties, claims, actions, judgments, suits, costs, expenses or disbursements (including reasonable attorney's fees and expenses) (for the purposes of this Section the foregoing are collectively called "Indemnified Liabilities") for whatsoever kind or nature which may be imposed on, asserted against or incurred by any of the Indemnitees in any way relating to or arising out of this section of the General Rules or in any other way connected with the Incident, the provision by Wabash of the Benefits or the enforcement of any of the terms hereof or the preservation of any rights hereunder; provided, that no Indemnitees shall be indemnified pursuant to this Section for Indemnified Liabilities to the extent caused by the gross negligence or willful misconduct of such Indemnitees; (ii) pay to, or reimburse, Wabash for, any and all fees, costs and expenses of whatever kind or nature incurred in connection with the preservation or protection of Wabash's rights hereunder, including, without limitation, all fees and advances, costs and expenses in connection with protecting, maintaining or preserving Wabash's rights through judicial proceedings or otherwise, or in defending or prosecuting any actions, suits or proceedings arising out of or relating to the undertakings herein described to the fullest extent allowed and/or permitted by ERISA; (iii) without limiting the application of any other duty or language herein described, the Claimant shall pay, defend, indemnify, reimburse and hold harmless each of the Indemnitees from and against any Indemnified Liabilities which such Indemnitees may suffer, expend or incur in consequence of or growing out of any misrepresentation by the Claimant in the Claimant's obtaining of Benefits from Wabash to the fullest extent allowed or permitted by ERISA.

14. While any indebtedness or obligation is owing to Wabash hereunder, the Claimant shall not enter into any agreement, relationship, or understanding, with any Person which impairs, or diminishes (or purports to impair or diminish), any rights, claims, or interests, of Wabash hereunder, or in the Action, and to the extent any later agreement, relationship, or understanding is effectuated to the contrary, said later agreement, relationship, or understanding shall be deemed void and unenforceable.

15. Upon any receipt by the Claimant or Person acting on behalf of the Claimant, of monies, funds, or things of value from any RP, the Claimant will immediately pay to Wabash, in good and collectible United States funds, the entire amount owed to Wabash hereunder, which payment shall be made no later than thirty (30) days after receipt of such funds by the Claimant. Should the Claimant fail, for any reason whatsoever, to remit such funds to Wabash as required hereunder in the time period set forth herein, the Claimant agrees that the Claimant will pay to Wabash (in addition to all other amounts owed by the Claimant to Wabash)

interest accruing on any unpaid balance of funds owed to Wabash hereunder at the rate of ten percent (10%) per annum (exclusive of the thirty (30) day period set forth above) until the entire balance is paid in full.

16. The proceeds or funds paid to Wabash by the Claimant hereunder shall be applied as follows: (i) first, to the payment of any and all reasonable expenses and fees (including reasonable attorneys' fees and disbursements) incurred by Wabash in connection with the exercise of its rights and remedies hereunder; (ii) second, in satisfaction of accrued but unpaid interest owed by the Claimant to Wabash; (iii) third, to satisfy (inasmuch as may be appropriate) the principal balance owed to Wabash by the Claimant for the Benefits provided to, or for the benefit of, the Claimant; and (iv) fourth, to any other debt or amount owed to Wabash by the Claimant.

17. The Claimant should understand that Benefits paid or provided by Wabash to the Claimant, or on Claimant's behalf, are made under the condition that the Claimant will execute such written authority as may be required to enable Wabash to recover said Benefits upon recovery by the Claimant of any funds, monies, consideration, or things of value from any Responsible Person,. and the Claimant shall execute such necessary documents and cooperate in order to ensure that Wabash receives such reimbursement.

(c) The Claimant shall notify Wabash immediately of any settlement or resolution of any Action, which notification shall be in writing.

(d) For a period of twenty-four (24) months after the date of resolution of any Action, Wabash shall be indemnified from the cost of any medical care related to the injury, illness or disease for which the Claimant has received monetary compensation from, or on behalf of, the RP, and during said period, no benefits shall otherwise be available from Wabash for the

Claimant for any injury, harm, disease or illness described by the Claimant as arising from the Incident.

18. For any and all healthcare benefits, treatments, medical devices, examinations, therapies, diagnoses, pharmaceuticals, funds, monies, reimbursement, or payments made by Wabash to, or for the benefit of, the Claimant, or other monies, funds, or things of value provided by Wabash to, or for the benefit of, the Claimant as a result of any claim or request by the Claimant for such benefits following the date of the Incident, a presumption shall arise that such shall be included within the definition of "Benefits" hereunder and shall be reimbursed by the Claimant to Wabash, in full, in the same manner as other Benefits are to be reimbursed by the Claimant to Wabash in full hereunder.

For any and all healthcare benefits, treatments, medical devices, examinations, therapies, diagnoses, pharmaceuticals, funds, monies, reimbursement, or payment made by Wabash to, or for the benefit of, the Claimant, or other monies, funds, or things of value

provided by Wabash to, or for the benefit of, the Claimant as a result of any claim or request by the Claimant for such benefits following the date of the Incident, and for which the Claimant advances or asserts any claim, demand, assertion or allegation of liability therefor against an RP, a conclusive presumption shall arise that such shall be included within the definition of "Benefits" hereunder and shall be reimbursed by the Claimant to Wabash, in full, in the same manner as other Benefits are to be reimbursed by the Claimant to Wabash in full hereunder.

The presumption(s) herein described shall not arise or exist to the extent that the Claimant truthfully and accurately informs Wabash in writing that such later occurrence, event, treatment or healthcare benefit is unrelated to the Incident, and Wabash acknowledges receipt of such written notification by a written communication from Wabash to the Claimant, and Wabash agrees with the information contained within the Claimant's written notification to Wabash.

19. Unless otherwise provided by the Claimant in writing to Wabash, all notices or written communications to the Claimant by or from Wabash may be sent by first class mail deliverable by the United States Postal Service with postage fully prepaid at the address for the Claimant as held or recorded by Wabash on its books and records. Reasonable alternatives to use of the United States Postal Service also shall be permitted. The Claimant is free to authorize Wabash to communicate directly with an attorney or representative of the Claimant, and Wabash shall comply with such authorization until revoked or modified by the Claimant as such may be allowed by applicable law.

20. Where practicable, Wabash shall endeavor to communicate reasonably with the Claimant in connection with matters known to Wabash and material to the matters herein described.

21. In case or in the event that any provision in or obligation hereunder shall be deemed invalid, illegal or unenforceable by a court of competent jurisdiction, the validity, legality and enforceability of the remaining provisions rights, interests or obligations hereof shall not in any way be affected or impaired thereby.

22. To the extent not otherwise governed by ERISA and/or federal common law interpreting or applying ERISA, the law governing the rights, duties and interests herein described shall be the laws of the State of Illinois, notwithstanding the conflict of laws provisions thereof. Any provision of any other law of any state providing for satisfaction of duties otherwise owed by the Claimant to Wabash in an amount less than full reimbursement to Wabash of all Benefits provided by Wabash to, or for the benefit of, the Claimant (for example, and described solely for illustrative purposes, any "make whole" doctrine) shall be of no effect whatsoever.

23. Any and all notices, documents, or materials, required to be provided hereunder by the Claimant to Wabash, shall be deemed to have been provided when mailed with full postage prepaid and properly addressed to the following:

Wabash Memorial Hospital Association
Attention: Administrator
1501 North Water Street
Decatur, Illinois 62526

24. Wabash shall retain the right to compromise any lien or right of reimbursement herein described, but any such compromise thereof shall be within the sole and exclusive discretion of Wabash.

Appeals

CLAIM APPEAL PROCESS

Any member who questions or disagrees with the coverage determination on a claim may ask to have the claim reviewed. The Plan Administrator is empowered for the ultimate decision on interpretation of benefits, rules and regulations under the terms of the Plan. Thus, any benefits payable under the Plan are subject to the discretion of the Plan Administrator.

The claims appeal process shall have three distinct levels:

a. First Level Appeal

The first level appeal is determined by the Claims Manager. A written request for review must be submitted to Wabash within sixty (60) days of the initial claim determination date. The written request for review must include the member's 1) name; 2) mailing address and 3) Social Security number. The written request must state the reason(s) the member believes that the claim was processed incorrectly, or the reasons that the claim should have been approved. A member is not required to submit additional information to support a request; however, it may be helpful to the member to include additional information to clarify or support his/her position.

The written request for review should be submitted to:
Claims Manager
ATTN: Appeals
Wabash Memorial Hospital Association
P.O. Box 1340
Decatur, IL 62525-1340

The Claims Manager will issue a decision within sixty (60) days from the date the appeal is received by Wabash. The decision issued by the Claims Manager will be provided to the member in writing, and shall include the reasons for the decision reached by the Claims Manager.

If the time required for a first level appeal would seriously jeopardize the life or health of the member, a request for expedited review may be submitted by facsimile to the Plan Administrator. A decision will be made within seventy-two (72) hours of receipt of a request for an expedited review.

b. Second Level Appeal

A member who questions or disagrees with the decision of the Claims Manager may appeal that decision. Second level appeals are decided by the Plan Administrator. A written request for review of the Claims Manager's decision must be submitted to Wabash within thirty (30)

days of the date the decision was rendered by the Claims Manager. Second level appeals will be decided by the Plan Administrator within a reasonable period of time, but not later than thirty (30) days after the Plan Administrator receives the written request for appeal. The written request for a second level appeal shall include all information required in a first level appeal. The written request for review at the second level of appeal should be submitted to:

Plan Administrator
ATTN: Appeals
Wabash Memorial Hospital Association
P.O. Box 1340
Decatur, IL 62525-1340

The Plan Administrator's decision will be provided to the member in writing, and shall include the reasons for the decision reached by the Plan Administrator.

c. Third (Final) Level Appeal

If a member disagrees with the second level appeal decision by the Plan Administrator, the member has the right to make a third (final)level appeal of the coverage determination to the Board of Managers. The Board of Managers will apply a highly deferential standard of review to the prior second level appeal decision of the Plan Administrator. The Board of Managers will overturn the Plan Administrator's decision only if the Plan Administrator's decision was arbitrary, capricious and/or against the manifest weight of the evidence

The member must make this final request for review within thirty (30) days of the date the second level appeal decision of the Plan Administrator is rendered. The written request for a third level appeal shall include all information required in a first and second level appeal. A written request for final review must be submitted to Wabash at the following address:

Board of Managers
ATTN: Appeals
The Wabash Memorial Hospital Association
P.O. Box 1340
Decatur, IL 62525-1340

Final appeals to the Board of Managers will be decided within a reasonable period of time, but not later than sixty (60) days after the Board of Managers receives the request for final appeal. The Board of Manager's decision will be provided to the member in writing, and shall state the reasons for the Board of Manager's decision. Once the Board of Managers has rendered a final review decision, that decision may not be appealed.

Glossary

This glossary has many commonly used terms, but it is not a complete list.

Allowable Charge– Maximum amount on which payment is based for covered healthcare services. If your provider charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal – A request for the plan to review coverage determination on a claim.

Balance Billing – When a provider bills you for the difference between the providers charge and the allowed amount. For example, if the provider charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider, or network provider, cannot bill this difference. However, providers outside the network may balance bill the patient.

Co-insurance – Your share of the costs of a covered health care service after plan payment. Co-payment may be calculated as a fixed amount or as a percent (for example, 20%) of the allowed covered charge. You pay co-insurance plus any deductibles you owe. For example, if the plan's allowed amount for an office visit is $100 and you've met your deductible, your co-payment of 20% would be $20. The plan pays the remaining amount of $80.

Complications of Pregnancy – Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarian section are not complications of pregnancy.

Co-payment – A fixed amount (for example $15)you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible – The amount you are required to pay for health care service your benefit coverage before the plan begins to pay.

Durable Medical Equipment (DME) – Equipment and supplies ordered by a healthcare provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs crutches or blood testing strips for diabetics.

Emergency Medical Condition – Any illness, injury, symptoms or conditions so serious that it is considered life threatening or so emergent that a reasonable person would seek care right away to avoid serious harm.

Emergency Medical Transportation- Ambulance services for an emergency medical condition.

Emergency Room Care – Emergency services received in an emergency room.

Emergency Services – Evaluation of an emergency medical condition and treatments to keep that condition from getting worse.

Excluded Services – Health care services that the plan does not cover.

Home Health Care – Health care services provided by a licensed agency to a member in his/her place of residence as prescribed by a licensed provider

Hospice Services – Services to provide palliative care and treatment for members in the last stages of a terminal illness as prescribed by a licensed provider

Hospitalization – Care in a hospital that requires admission as an inpatient.

Hospital Outpatient Care – Care in a hospital that does not require an overnight stay.

Medically Necessary – Health care services or supplies needed to prevent, evaluate, diagnosis or treat an illness, injury, disease, or its symptoms and that meet accepted standards of medicine; are clinically appropriate in terms of type, frequency, extent, site , duration, and effective for the patient's condition; and not for the convenience of the patient or provider and not more costly than an alternative service likely to produce equivalent treatment results

Network – The facilities, providers and suppliers the plan has contracted with to provide health care services.

Out of Network Provider – A provider who does not have a contract with the plan to provide services. You will pay more to see an out of network provider.

Out-of-Pocket Limits – The most you pay during a policy period before the plan begins to pay the allowed amount. This limit never includes your dues premium, balanced billed charges or health care the plan does not cover .

Physician Services – Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan – The terms and benefits provided to pay for your health care services.

Precertification – The plan's decision required prior to receipt of services that the services are approved as medically necessary. Precertification is not a promise or guarantee that the plan will cover the cost of the services.

Network Provider – A provider who has a contract with the plan to provide services to you at a discount.

Dues Premium – The amount that members pay to the plan to receive health benefit coverage.

Prescription Drugs – Drugs and medications that by law require a prescription.

Primary Care Provider - A physician (M.D – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider - A physician (M.D – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery – Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitative Services – Health care services that help a member keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Facility – Medicare certified and Licensed facility that provides continuous 24 hours a day skilled nursing care during the convalescent stage of an injury or sickness.

Specialist – A provider with specialized training that focuses on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

UCR (Usual, Customary and Reasonable) - The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care – Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.