Wabash Memorial

Hospital Association

Handbook
Medicare Plans

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 - 2017

Dan Calhoun
Sheet Metal, Air, Rail and Transportation Workers

Todd Clark
Brotherhood of Railroad Signalmen

Steve Henley
International Association of Machinists & Aerospace Workers

Tim Hunt, Vice Chairman
National Conference of Firemen and Oilers

Chris Jones
International Brotherhood of Electrical Workers

Jason Shannon, Chairman
Brotherhood of Locomotive Engineers & Trainmen

R. C. Smith
Retiree Representative

Roger Snively
Retiree Representative (Alternate)

Tim Southerland
Affiliated System Federation Brotherhood of Maintenance of Way

Tracey Sumpter
Brotherhood of Railroad Carmen

Wabash Administration
Julie Riggen, Administrator

Important Information

Purpose of the Plan: The Wabash Memorial Hospital Association Health and Welfare Plan (the "plan") provides healthcare benefits to employees and retirees (and their dependents) of the Wabash, St. Louis and Pacific Railroad Company. This plan document describes the terms of the Medicare supplemental plan component of the plan in effect as of January 1, 2017. Medicare supplemental plan benefits will be provided in accordance with this plan document, the applicable healthcare benefit coverage schedule, and the rules, regulations and bylaws of the Wabash Memorial Hospital Association ("Wabash"), as approved by the Board of Managers, which are incorporated by reference into this plan document.

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.

Right to Interpret: Wabash, as the plan's administrator, reserves broad discretionary authority to interpret this plan document and to determine any member's eligibility for benefits under the plan. If this document includes any errors and/or omissions, Wabash reserves the right to interpret this document in accordance with its original intent and not how it may appear through an error.

Oral Or Other Unofficial Modifications Are Not Permitted: This plan document governing the plan cannot be modified by oral statements made by anyone, or by unofficial communications (such as e-mail or mailings) or any other contracts (such as employment contracts). The plan can only be amended in writing by official amendments.

Future of Plan: 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. Upon the plan's termination, any remaining assets would be subject to disposition in accordance with applicable law.

Wabash may also increase the required employee or retiree contributions at any time. Similarly, Norfolk Southern Corporation ("NSC") 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.

Member Responsibilities: You must notify Wabash when you have a change in address or a change that affects you or your dependent's eligibility under the plan.

You must also inform Wabash of the addition or termination of any other health plan coverage you may have. The plan coordinates the benefits it provides with the benefits you receive from other health plans. Failure to notify Wabash about the addition or termination of other health plan coverage can delay your receipt of benefits under the plan.

Non-Assignment of Benefits: A claim for benefits, and any other right or benefit under the plan or ERISA (including the right to sue), cannot be assigned or transferred in whole or in part to any person or entity, including any provider, at any time before or after covered services are rendered. Coverage under the plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage, or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer will be null and void.

Notwithstanding the foregoing, Wabash may make any benefit payments directly to the provider, and Wabash is specifically authorized by you to determine to whom any benefit payment should be made. Once covered services are rendered by a provider, you cannot request that the plan ignore the claim submitted by such provider. No such request will be given effect.

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 the Authorization for Release of Protected Health Information form is available to participants at www.wabashcannonball.org.

Newborns' and Mothers' Health Protection Act: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any length of stay in connection with childbirth for the mother or her newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, plans and issuers may not under federal law require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 or 96 hours, as applicable, or offer incentives to shorten lengths of stay.

Eligibility and Participation

Eligibility – Wabash membership in a Medicare supplemental plan is available to:

Retired Railroader – on Medicare

a. any retired railroad worker that is Medicare eligible, provided that the railroad worker had 5 years of service with the railroad, regardless which railroad by which they were employed

Non-Railroaders – on Medicare

a. any current Wabash member
b. the following Medicare eligible relatives:
    i. Current spouse or widow(er) of anyone currently or previously employed by the railroad or Wabash for at least five years
    ii. 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. 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.

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 under your coverage schedule. Members should refer to their individual coverage schedule for additional conditions or contact Member Services prior to receiving services.

Abortion – Except as necessary to protect the 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 substance abuse program, for prescription medication monitoring, 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 – Coverage for routine eye examinations are limited to once per calendar year and are provided secondary to other coverage. The plan excludes:

- 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 member 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.

Other Payors

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.

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

Order of Payment: If there is another payor, plan benefits will be determined as follows:

(a) Primary Plan Coverage. If Wabash is primary payor, benefits will be determined without regard to benefits provided under any other plan. Wabash determines whether it is the primary payor as follows:

1. The primary plan with no coordination of benefits provision will be first payor.

2. If the primary payor is not determined by 1. above, the plan covering the person as an active employee will be primary payor.

3. If the primary payor is not determined by 1. or 2. above, the plan that has covered the person for the longer period of time will be primary payor.

(b) Secondary Plan Coverage. When Wabash 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 amount the plan would pay if it were the primary payor.

Maximum Combined Benefit: The combined benefits paid by this plan and all other payors will 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.

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 Wabash 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.

Overpayment of Benefits: In the event of any overpayment of benefits by the plan, the 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 the 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.

Claims and Appeals

Any member who questions or disagrees with the coverage determination on a claim may ask to have the claim reviewed. The claims procedure described in this section is intended to provide a fair review of whether the terms of the plan have been followed in your case.

Information required by the Wabash may be provided in any form or document that Wabash considers acceptable. Wabash relies on the information provided when evaluating coverage and benefits under the plan. All such information must be accurate, truthful and complete. Wabash is entitled to conclusively rely upon, and will be protected for any action taken in good faith in relying upon, any information provided to Wabash. 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.

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.

Claim 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.

Claim Denials: If your claim is wholly or partially denied, you will be furnished with a written or electronic notice of the denial which will explain:

- The specific reasons for the denial;
- Plan provisions on which the denial was based;
- additional material or information needed to make the request for benefits acceptable and the reason it is necessary; and
- A statement disclosing any internal rule, guideline, protocol, or similar criteria relied upon in denying your claim (or a statement that such information will be provided free of charge upon request);
- If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment (or a statement that such an explanation is available upon request); and
- The procedure for appealing the denied request for benefits.

Your initial claim will be decided within the time period applicable to your claim type, as described in the section below titled “Timing of Claim and Appeal Determinations.”

Types of claims
The timing of the claims and appeal process is based on the type of claim. If you wish to appeal a claim, it helps to understand whether it is an:
urgent care;

pre-service; or

post-service claim.

How to Appeal a Denied Claim: If all or any portion of your claim is denied and you want to pursue the matter further, you (or your Authorized Representative) must, within 180 days after you receive the denial, file a written appeal as described below. However, you do not need to submit Urgent Care appeals in writing. Your appeal should describe all of the reasons you believe the claim denial was in error, and should include all written comments, documents, records and other information that you have relating to your claim and that you want to have considered in support of your appeal. Your appeal will be decided based on all the available information, and the information you submit will be considered even if it wasn't considered in the initial determination. So you should make sure that your submission is complete.

During the 180-day period you have to file your appeal, you will have the opportunity to review upon request documents, records and other information relevant to your claim for benefits. You may also request copies (free of charge). If the advice of a medical expert was obtained in connection with the initial benefit decision, the name of each expert will be provided upon request, regardless of whether the advice was relied on in making the decision on your claim.

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

Review of First Level Appeals: The Claims Manager will conduct a full and fair review of your appeal, without deference to the initial claim decision. If your claim was denied based on medical judgment, the Claims Manager will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse decision nor is the subordinate of anyone consulted in connection with the initial adverse decision.

The Claims Manager will decide your first level appeal within the time period applicable to your claim type, as described in the section below titled "Timing of Claim and Appeal Determinations." You will receive a written decision including the specific reason(s) and plan references on which the decision is based. For urgent care claim appeals, you may be notified by telephone with written notice to follow.

Second Level Appeals: If you disagree with the decision of the Claims Manager, you (or your Authorized Representative) may appeal that decision to the Plan Administrator. The written request for a second level appeal shall include all information required in a first level appeal.

During the period you have to file your appeal, you will have the opportunity to review upon request documents, records and other information relevant to your claim for benefits. You may also request copies (free of charge).

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 you in writing, and shall include the reasons for the decision reached by the Plan Administrator. For urgent care claim appeals, you may be notified by telephone with written notice to follow.

Timing of Claim and Appeal Determinations: Separate schedules apply to the timing of claims and appeals, depending on the type of claim. There are three types of claims:

- Urgent Care - a claim for benefits provided in connection with Urgent Care services, as defined in the Glossary below;
- Pre-Service - a claim for benefits for which the Plan requires precertification or other prior approval before the non-Urgent Care service is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care care that has already been provided.

A member may call or send a letter to Wabash to ask whether a benefit is available under the Plan. Unless the Plan requires precertification or other prior approval for the requested benefit, inquiries about coverage for services you may receive in the future are not pre-service claims and are not subject to these claim procedures. If you are unsure about the status of any inquiry or claim request, you should contact the Claims Manager.

The table below describes the timeframes which you and the plan are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for benefits is incomplete or filed improperly, you will be notified within:	**24 hours**
You must then provide a completed request for benefits	**48 hours** after receiving notice

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
within:	of additional information required
You will be notified of the benefit determination within:	**72 hours** (or **48 hours** after you supplied additional information)
If you claim is denied, you must appeal the adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Manager will notify you of the appeal decision within:	**72 hours** after receiving the appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Plan Administrator must notify you of the second level appeal decision within:	**72 hours** after receiving the second level appeal

*You do not need to submit Urgent Care appeals in writing. You should call the Claims Manager as soon as possible to appeal an Urgent Care request for benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for benefits is filed improperly, you will be notified within:	**5 days**
If your request for Benefits is incomplete, you will be notified within:	**15 days**
You must then provide completed request for Benefits information to the Claims Manager within:	**45 days**
The Claims Manager must notify you of the benefit determination:	
■ if the initial request for benefits is complete, within:	**15 days***
■ after receiving the completed request for benefits (if the initial request for benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Manager must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Plan Administrator must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

* This period may be extended by 15 days, provided that such an extension is necessary due to matters beyond the control of the plan and you are notified, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to make a claim decision.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, you will be notified within:	**30 days**
You must then provide completed claim information within:	**45 days**
The claims Claims Manager must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days***
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Manager will notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Plan Administrator must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

***** This period may be extended by 15 days, provided that such an extension is necessary due to matters beyond the control of the plan and you are notified, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to make a claim decision.

g. 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 Manager 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 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.

h. Voluntary Third Level Appeals

If you disagree with the second level appeal decision by the Plan Administrator, you may, but are not required to, make a voluntary third level appeal of the coverage determination to the Board of Managers. There is no fee to file a voluntary third level appeal, and your decision as to whether or not to file a voluntary third level appeal will have no effect on your rights to any other benefits under the plan.

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.

If you wish to file a voluntary third level appeal, you must do so within thirty (30) days after the Plan Administrator renders its decision on your second level appeal decision. 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

Voluntary third level 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. If the Board of Managers denies your voluntary third level appeal, you may challenge that decision only through legal action.

i. Legal Actions

If your second level appeal is denied, you have the right to file a lawsuit challenging the denial. The claims procedures described above, except the voluntary third level appeal, are required by

federal law and are designed to ensure that disputes regarding the plan are decided by the appropriate plan fiduciaries. Therefore, you must exhaust the plan's internal claims procedures before filing suit. If you fail to do so, the court will likely dismiss your lawsuit. You are not required to file the voluntary third level appeal, but have the choice to do so.

In a lawsuit, the court generally will review a decision on appeal based on the evidence and arguments that were presented. Except in rare circumstances, the court will not allow you to introduce new evidence or arguments to support your claim. Thus, you should make sure that everything that you believe supports your position is submitted to the appropriate plan fiduciaries during the claims process.

If you have completed the internal claims process above and want to bring a lawsuit, you must do so within the shorter of one (1) year of the final denial of your second level appeal or three (3) years from the date of the services giving rise to the claim. This time period is tolled while any voluntary third level appeal is pending. If you want to bring a lawsuit related to the plan for any reason other than to claim a benefit, you must do so within one year of the act or omission giving rise to the claim. Failure to file a lawsuit within these time periods will cause your rights to expire.

The plan is governed by ERISA, and state law is generally preempted. To the extent state law is not preempted, the plan is governed by the laws of the State of Illinois. All lawsuits arising under the plan or relating to the plan must be submitted to the United States District Court for the Central District of Illinois. By participating in the plan, or by asserting an entitlement to any right or benefit under the plan, you consent to the United States District Court for the Central District of Illinois' exercise of personal jurisdiction over you, and waive any argument that that forum is not a convenient forum in which to resolve the lawsuit.

j. Scope of Discretionary Authority

Wabash, as the plan's administrator, and any entity who acts on behalf of Wabash in deciding claims or appeals under the plan, has the discretionary authority to determine claims and appeals, and has the discretionary authority to interpret all terms of the plan and make factual determinations necessary to make the claim and appeal determinations. The decision made by the appropriate plan fiduciary on review is final and binding, subject to your right to file a lawsuit under ERISA or other applicable law. This decision-making authority is very broad and is limited only by the duties imposed under ERISA. The determination is intended to be given deference by courts to the maximum extent allowed under ERISA.

Subrogation, Reimbursement & Responsible Person or RP Recovery

General

If a Claimant or beneficiary becomes ill or is injured by the actions of a Responsible Person or RP, the costs associated with the illness or injury should be paid by the Responsible Person or RP. For example, if the injury is the result of a vehicle collision caused by another driver, the driver or his or her insurance company may be liable for payment of medical expenses. If the injury occurs at work or while on the job, an employer may be responsible for payment of medical expenses. This Plan does not pay for claims where a Responsible Person or RP is liable, however, subject to terms, conditions and within the Plan Administrator's discretionary authority, the Plan may agree to advance Benefits for the illness or injury with the understanding that these Benefits will be repaid to the Plan from any Recovery received from the Responsible Person or RP for the illness or injury.

In addition, the Plan maintains a right of Subrogation, meaning the right of the Plan to be substituted in place of the person who received Benefits with respect to any lawful claim, demand, or right of action against any Responsible Person or RP who may be liable for the injury, Illness or medical condition that resulted in payment of Plan Benefits. The Responsible Person or RP may not be the actual person who caused the injury, and may include an insurer to whom premiums have been paid.

If a Claimant becomes ill or is injured and a Responsible Person or RP is or may be responsible for such illness or injury, the Plan may advance payment of Benefits for such injury or illness provided that the requirements of this section are satisfied. By accepting Benefits under the Plan, the affected Claimant agrees to be subject to the terms and conditions of this Section regarding Subrogation, Reimbursement, and Responsible Person and RP Recovery. The Plan intends that neither the affected Claimant nor any other person may profit from the payment of Benefits or the payment of any compensation for injuries under the Plan. The purpose of the Plan is to pay covered expenses if they are not paid or payable by anyone else, in accordance with the terms of the Plan. The Plan Administrator has discretion to interpret and apply the terms of this Section.

Definitions

The following definitions shall apply to this section ("Subrogation, Reimbursement & Responsible Person or RP Recovery"):

(a) 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).

(b) Benefits shall mean any and all treatments, medical devices, examinations, therapies, diagnoses, pharmaceuticals, funds, monies, reimbursement, or payment, including any access fee paid to any provider network discounting any medical claim of the Claimant, 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)

(c) 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.

(d) 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.

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

(f) Recovery shall mean any and all payments from another source to which the Claimant is entitled (including, but not limited to, any amounts allocated to a trust set up by the Claimant or on the Claimant's behalf) as a result of the Claimant's injury or illness, including any judgment, award, or settlement regardless of how the recovery is termed, allocated, or apportioned and regardless of whether any amount is specifically included or excluded as medical expenses including but not limited to recovery designated as pain and suffering, noneconomic damages, and/or general damages.

The Plan's right of recovery extends to any amount paid by the Plan that is in any way related to the injuries incurred, whether paid directly or indirectly to the injured party, the injured party's spouse, dependents, beneficiaries or estate, and whether held in trust or constructive trust for the benefit of any of those parties.

(g) Reimbursement Amount shall mean the amount of Benefits paid by the Plan to the Claimant or on the Claimant's behalf for the injury or illness for which a Responsible Person or RP is or may be responsible and that the Claimant is obligated to pay back to the Plan per the terms of this Section out of any Recovery.

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.

(h) Responsible Person or RP means a person or entity that is or may be legally responsible for reimbursing the Claimant for an injury or illness. The term "Responsible Person or RP" includes any of the following entities: person; corporation; association; government; insurance coverage, including uninsured/underinsured motorist (UM/UIM), personal umbrella coverage, personal injury protection (PIP) insurance, medical payments coverage from any source or workers' compensation coverage.

(i) **Subrogation** means is the Recovery, from a Responsible Person or RP, of medical costs and other Benefits that were originally paid by the Benefits Plan to or on behalf of the Claimant of the Plan.

(j) **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).

Reimbursement and Subrogation Rights

The Plan, within its Plan Administrator's discretionary authority under this Section and the terms of the Plan, may agree to advance payment of Benefits for a Claimant's illness or injury for which a Responsible Person or RP is or may be responsible provided that the Claimant agrees to repay the Plan in full for Benefits advanced out of any Recovery. As a condition for advancing payment of Benefits for such injury or illness, the Claimant and the Claimant's attorney (if one is retained) may be required to sign the Plan's Acknowledgement Of The Wabash Memorial Hospital Association Benefit Plan Provisions document or other required documents if so requested by the Plan. If the Plan advances payment of Benefits to the Claimant for an injury or illness for which a Responsible Person or RP is responsible, the Plan is entitled to reimbursement in full for any Benefits paid to or on behalf of the Claimant. The Plan shall be subrogated to all of the Claimant's rights of recovery against the Responsible Person or RP to the full extent of Benefits advanced by the Plan.

(a) The Plan shall be entitled to reimbursement in full for any Benefits it advances to, or on behalf of, Claimants for expenses related to an injury or illness for which a Responsible Person or RP is, or may be, responsible without regard to the common fund doctrine, a Claimant's attorney fees or legal expenses, make whole doctrine, a Claimant's negligence or fault, or any other common law doctrine or state statute that purports to restrict the Plan's right to reimbursement in full in accordance with applicable law. The reimbursement to the Plan shall be made directly from the Responsible Person or RP or from the Claimant, the Claimant's attorney or the Claimant's estate out of any Recovery.

(b) The Plan shall be reimbursed first and in full out of any Recovery without any amounts deducted for attorney's fees, costs, or future medical expenses. 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.

(c) The Plan's right to reimbursement first and in full shall apply even if the Recovery is not sufficient to fully compensate the Claimant for his or her illness or injury and even if liability is not admitted or found.

(d) The Plan may seek reimbursement from any Recovery, whether by settlement, judgment, mediation, arbitration, or any other Recovery made by or on behalf of:

- A covered Beneficiary
- The estate of any Claimant covered person, or
- On behalf of any incapacitated Claimant or covered person

(e) The Plan's Recovery and Reimbursement Amount are recoverable even if the Claimant's recovery funds have been commingled with other assets and the Plan may recover from any available funds without the need to trace the source of the funds.

(f) Any party who distributes Claimant's recovery funds without regard to the Plan's rights of Subrogation or Reimbursement will be personally liable to the Plan for the amounts so distributed including Claimant's spouse, dependents, beneficiary, estate, including the Claimant's attorney.

(g) The Plan requires the Claimant's legal representative or estate to cooperate fully with the Plan and not take any actions that would prejudice the Plan's right of reimbursement.

(h) The Plan may exercise its right of subrogation and pursue a suit or claim against the Responsible Person or RP if the Plan, within its Plan Administrator's discretionary authority, elects to do so.

(i) The Plan shall have the right to join or intervene in any suit or claim against a Responsible Person or RP brought by Claimant or on the Claimant's behalf.

(j) The Plan shall have the right to information about any suit or claim brought by the Claimant or on the Claimant's behalf, including information on all claims, defenses, demands, and settlement communications by any party.

(k) No Claimant or his/her representatives may assign any rights or causes of action that he or she might have against a Responsible Person or RP tortfeasor, person, or entity, which would grant the covered individual the right to recover medical expenses or other damages, without the express, prior written consent of the Plan. The Plan's Subrogation and Reimbursement rights apply even if the Claimant or covered individual has died as a result of his or her personal injuries and is asserting a wrongful death or survivor claim against the Responsible Person or RP under the laws of any state. The Plan's right to recover by subrogation or reimbursement shall apply to any settlements, recoveries, or causes of action owned or obtained by a decedent, minor, incompetent, or disabled person.

Claimants' Reimbursement and Subrogation Responsibilities

The Plan shall deny or delay claims related to an injury or illness that may be caused by a Responsible Person or RP, or it may recoup the costs of claims already paid for such injury or illness, or offset any related and non-related incoming claims for benefits if any of the following requirements are not satisfied:

(a) The Claimant shall notify the Plan in writing of the existence of the injury or illness for which a Responsible Person or RP may be responsible immediately and no later than 30 days of any claim that may give rise to the Plan's claim for Subrogation or Reimbursement.

(b) The Claimant or Claimant's legal representative must, within 14 business days of receiving a request from the Plan, provide all information and sign and return all documents necessary to exercise the Plan's reimbursement rights under this Section.

(c) The Claimant shall comply with all of the Plan's claim and records procedures and cooperate fully with the Plan in the recovery of the Benefits advanced by the Plan and the Plan's exercise of its reimbursement and subrogation rights.

(d) The Claimant shall complete and submit to the Plan an Accident/Injury Report Form, an Acknowledgement Of The Wabash Memorial Hospital Association Benefit Plan Provisions document if requested, and any other documents required by the Plan. If requested by the Plan pursuant to its Plan Administrator's discretionary authority, an Acknowledgement Of The Wabash Memorial Hospital Association Benefit Plan Provisions document shall be reviewed, signed and returned to the Plan by the Claimant and Claimant's attorney if one is retained. It is the Claimant's responsibility to notify the Plan or its representatives immediately upon retention of an attorney.

(e) The Claimant shall agree to reimburse the Plan in full, in first priority and on a first dollar basis, from any Recovery in an amount equal to the full amount of Benefits advanced by the Plan for the Claimant's injury or illness, regardless of whether the Claimant is made whole by the Responsible Person or RP. The Claimant shall also agree that the common fund doctrine, make whole doctrine, and any other common law doctrine or state statute that purports to restrict the Plan's right to full reimbursement shall not be applicable to the Plan's right to full reimbursement of the amount of Benefits it advances to a Claimant under this Section in accordance with applicable law.

(f) The Claimant shall provide any and all information about the Claimant's illness or injury as requested by the Plan.

(g) The Claimant shall keep the Plan advised of any changes in the status of the Claimant's suit and/or claim against the Responsible Person or RP.

(h) The Claimant shall refrain from doing anything to impair, prejudice or compromise the Plan's subrogation and reimbursement rights without prior written agreement by the Plan's Administrator.

(i) The Claimant shall notify, and instruct their agents or attorneys to notify the Plan at least 14 days prior to any settlement or any trial or other material hearing concerning the suit or claim is held.

(j) The Claimant shall be solely responsible for the Claimant's attorney's fees or legal expenses. The Plan shall not be liable for any costs or attorney's fees incurred by the Claimant in pursuing the Claimant's suit or claim, regardless of any common fund, make whole, or any other

common law doctrine or state statute that requires the Plan to pay a portion of the Reimbursement Amount to the Claimant or the Claimant's attorney for the legal fees or legal expenses incurred in the collection of the Recovery. The Claimant shall defend/indemnify and hold harmless the Plan from any claims by the Claimant's attorney against the Plan seeking attorney's fees or costs.

(k) The Claimant shall inform the Plan as to whether he or she has received a Recovery related to the Claimant's illness or injury before signing the Acknowledgement Of The Wabash Memorial Hospital Association Benefits Plan Provisions document if one is requested. If Claimant receives a Recovery before the Acknowledgement Of The Wabash Memorial Hospital Association Benefits Plan Provisions is signed if requested, or an incident is reported, the Plan shall not be responsible for any further claims related to the illness or injury unless agreed in writing by the Plan.

(l) Any claims for a Claimant's illness or injury shall not be paid until the Plan has received a completed copy of the Acknowledgement Of The Wabash Memorial Hospital Association Benefits Plan Provisions signed by both the Claimant and the Claimant's attorney if requested by the Plan. If the Plan inadvertently advances payment for claims before requesting and receiving the completed and signed Acknowledgement Of The Wabash Memorial Hospital Association Benefits Plan Provisions document, the Plan shall not be obligated to advance payment for any further claims until it has received the fully completed and signed Acknowledgement Of The Wabash Memorial Hospital Association Benefits Plan Provisions document and the Plan shall be entitled to reimbursement by requesting refunds from providers for the claims that it had inadvertently paid regardless of whether the completed and signed Acknowledgement Of The Wabash Memorial Hospital Association Benefits Plan Provisions document is submitted to the Plan.

Reimbursement and Subrogation Procedures

The Claimant shall be responsible for compliance by his or her agents and attorneys with the procedures set forth in this Section. If the Claimant receives a Recovery, the Claimant or the Claimant's attorney shall hold the Recovery funds separately from other assets until the Plan's reimbursement rights have been satisfied. The Plan shall hold a claim, equitable lien, and constructive trust over any and all Recovery funds and those funds shall remain segregated and under the Claimant's or Claimant's agent's control. Once the Plan's reimbursement rights have been determined, the Claimant shall make immediate payment to the Plan out of the Recovery proceeds. Alternatively, or in addition, the Plan Administrator, in exercising its discretionary authority shall be entitled to assert a suit or claim in the Claimant's name or on the Claimant's behalf in the Plan's name and the Claimant shall cooperate with the Plan's prosecution of any such suit or claim. In exercising its rights under this Section, the Plan may consider, among other things, the sources of Recovery from any Responsible Person or RP or Parties, any claims and defenses in any action or potential action, the strength or weakness of any claims or defenses, and litigation risk.

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.

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.

Noncompliance

If the Claimant receives a Recovery but does not promptly segregate the Recovery funds and reimburse the Plan in full from those funds, the Plan shall be entitled to take action to recover the Reimbursement Amount. Such action shall include, but shall not be limited to:

(a) Initiating an action against the Claimant and/or the Claimant's attorneys to compel compliance with this Section and/or the Acknowledgement Of The Wabash Memorial Hospital Association Benefits Plan Provisions document;

(b) 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.

(c) Withholding or suspending Benefits payable to or on behalf of the Claimant and the Claimant's eligible Beneficiaries until the Claimant complies or until the Reimbursement Amount has been fully paid to the Plan; or

(d) Initiating other appropriate actions.

If the Claimant does not reimburse the Plan within sixty (60) days of receiving the Recovery, the Claimant shall be responsible for paying the Plan one (1%) percent interests per month on the Reimbursement Amount until the Plan receives reimbursement in full.

Mailing Address for Notices under this Section

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

Conclusion of Claim

Once a Claimant has settled or received an award or judgment or any type of Recovery on a claim or suit against a Responsible Person or RP, (1) the Claimant shall hold any proceeds of a Recovery in trust until the Plan's rights and interests in such Recovery have been resolved and satisfied and (2) 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.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Your Rights Under ERISA

As a participant in the plan, you are entitled to certain rights and protections under ERISA, the Employee Retirement Income Security Act of 1974.

Receive Information About Your Plan And Benefits: ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all 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 Security Administration.

- Obtain, upon written request to the plan administrator, 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 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 this summary annual report.

Continue Group Health Plan Coverage: You may be able to continue coverage if there is a loss of coverage under the plan as a result of a qualifying event. You may have to pay for such coverage. Review this summary and the documents governing the plan for the rule governing your COBRA continuation membership rights.

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, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights: If your claim for a 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the claims procedures outlined in this publication, 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. 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 Wabash at (217) 429-5246. 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, U.S. 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 publications hotline of the Employee Benefits Security Administration.

General Plan Information

Official Plan Name and Plan Number: The legal name of the plan is the Wabash Memorial Hospital Association Health and Welfare Plan. The plan number assigned to the plan is 501.

Type of Plan: The plan is an employee welfare benefit plan providing group medical benefits.

Plan Sponsor and Administrator: The name and address of the entity that established, and maintains, the plan is:

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

Wabash also serves as the plan administrator of the plan for purposes of ERISA.

Plan Sponsor's Employer Identification Number (EIN): The plan sponsor's employer identification number is 37-0806462.

Plan Effective Date: The Plan was originally established on May 27, 1984.

Plan Year: The plan year for the plan is the calendar year.

Agent for Service of Legal Process: Legal process may be served on the Wabash at the following address:

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

Plan Funding: The plan is funded by contributions from both the employer and employees. Assets of the plan are held in Trust by the Hickory Point Bank.

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.

Authorized Representative – A person you authorize in writing to act on your behalf in a claim or appeal under the plan. A person may serve as your Authorized Representative only if your written authorization is filed with Wabash. The plan will also recognize a court order giving a person authority to submit claims on your behalf.

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.

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.