

Wabash Memorial Hospital Association



**Handbook/Summary Plan Description
Primary and Secondary Plans**

Effective January 1, 2022

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

Dan Calhoun
Sheet Metal, Air, Rail and Transportation Workers

Todd Clark
Brotherhood of Railroad Signalmen

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International Association of Machinists & Aerospace Workers

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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 plan in effect as of January 1, 2022. Healthcare benefits will be provided in accordance with this plan document, applicable healthcare benefit summaries, 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.

Summary Plan Description (SPD): A summary of the terms and conditions of the plan.

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 the plan or amend 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: The plan 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.

Qualified Medical Child Support Order (QMCSO): A Qualified Medical Child Support Order (QMCSO) is an order or judgment from a court or administrative body, served on Wabash or the agent for service of legal process, directing Wabash to provide coverage for a member’s child.

To qualify as a QMCSO, it must:

- State the name and last known mailing of the employee and each child covered by the order
- Give a reasonable description of the type of coverage or benefits the plan must provide for each covered child
- Specify the period of time to which the order applies
- Clearly identify each plan to which the order applies

A QMCSO may not require the plan to provide any type of benefit not otherwise provided. When Wabash receives an order, the member and each child covered is notified of the order’s receipt, the procedure used to determine if the order is qualified, and whether or not it qualifies. Members and beneficiaries may receive, upon request to the Plan Administrator and without charge, a copy of the procedures applicable to QMCSOs.

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

Your Rights and Protections Against Surprise Medical Bills

Notwithstanding any other provisions in this booklet, the following protections against surprise medical bills apply, effective January 1, 2022.

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You **can’t** be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can’t** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

[When balance billing isn't allowed, you also have the following protections:](#)

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact 1-800-985-3059.

Visit: <https://www.cms.gov/nosurprises/consumers> for more information about your rights under federal law.

Eligibility and Participation – Active Railroaders

I. Norfolk Southern Corporation Employees (NSC)

- (a) **Active Railway Employees: Contract employees of NSC who have Board representation are entitled to primary coverage if the NSC has paid dues to Wabash on their behalf for the month in which benefits are sought. Primary coverage is provided through the Cannonball Plan's Benefit Summary. Contract employees who transfer to the former Wabash line are eligible for membership in Wabash. Coverage is provided in coordination with the group health insurance which is primary. When coverage with the group insurer is no longer in effect, Wabash provides primary coverage and the full rate for active dues will apply.**

For members affected by Health and Welfare Agreements, **NSC will remit to Wabash monthly an amount sufficient to cover those members as provided for in the Agreement.** Members whose dues are not paid through NSC shall pay their dues directly to Wabash.

- (b) **Furlough Status:** Membership for active members who are placed on furlough status by NSC will automatically continue until the end of the fourth month following the month in which they last rendered compensated service. These members will not be required to pay dues during this time if they maintain their employment relationship with NSC. After the end of the fourth month, COBRA coverage is available. If the member elects COBRA coverage, the four month waiver of dues will be deemed part of the COBRA eligibility period. At the end of the COBRA eligibility period these members are required to remit their dues directly to Wabash in order to maintain their membership. Members must notify Wabash when they are placed on furlough status or return to work.
- (c) **Sick Leave:** Active employees of the Railway who are not on the payroll due to illness or physical disability will be granted up to 12 months waiver of dues. The waiver does not apply to those members who sever their working relationship with NSC, even if they are retained on their seniority roster. At the end of the waiver period COBRA coverage is available. At the end of the COBRA eligibility period, the member will be required to pay dues at the applicable rate directly to Wabash. Members should notify Wabash when they are on sick leave. If a member exhausts an entire 12 month waiver of dues, in order to be eligible for an additional 12 month waiver of dues period, a member must return to active duty, or be marked up and available for active duty, for a minimum of 30 calendar days. A member is not permitted to use a sick day or vacation day to fulfill the requirement of active duty, but must actually return to work on active duty. If a member is furloughed during the 12 month waiver period, they will continue to be covered under the waiver provision as long as their disability is the only reason that they could not return to work if they had the opportunity to do so.

If a disability annuity is granted by the Railroad Retirement Board (RRB) during the waiver period, the member is required to pay dues **retroactive to the date of the annuity notification letter**. If an on duty injury settlement is received, dues will be paid retroactive to the effective date of the annuity or return to work date. However, the member will not be required to pay dues for any month that Wabash has received payment from NSC due to earned vacation compensation prior to the annuity date. It is the member's responsibility to provide Wabash

with a copy of the "Notice of Annuity Award".

(d) Dismissal or suspension: Coverage for dismissed or suspended employees who have been employed by NSC for at least six months will continue until the end of the fourth month following the month in which they last rendered compensated service. COBRA coverage is available following the fourth month. If the member elects COBRA coverage, the four month waiver of dues will be deemed part of the COBRA eligibility period. At the end of the COBRA eligibility period, members who have been employed by NSC for at least five years with continuous membership in Wabash may continue their membership by paying dues directly to Wabash

After the fourth month, members who have been employed by NSC for at least five years with continuous membership in Wabash may continue their membership by paying dues at the full Active rate directly to Wabash. This provision also applies to members who voluntarily leave the services of NSC.

If an employee is dismissed during the waiver of dues period (covered in (c) above), their coverage will continue throughout the hearing process. If the dismissal is reversed, the waiver of dues will continue on until the employee either returns to work or the waiver of dues expires. At that point, the employee may elect to pay the applicable dues directly to Wabash to maintain coverage, providing that he / she has been employed by NSC for at least five (5) years and maintained continuous membership in Wabash during that time.

Any member who has appealed their dismissal in accordance with NSC procedures may continue their membership in Wabash following the four month waiver period by paying COBRA dues directly to Wabash until a final decision is reached regarding the dismissal, if Wabash is advised in writing by the union that such an appeal is in process.

If the dismissal is reversed, the waiver of dues will continue on until the employee either returns to work or the four month waiver of dues period expires. At that point, the employee may elect COBRA coverage. At the end of the COBRA eligibility period the employee may continue coverage at applicable rates provide that he/she has been employed by NSC for at least five (5) years and maintained continuous membership in Wabash during that time.

If the dismissal is upheld during the hearing process, their coverage will terminate at the end of the month in which the decision was rendered. The member may elect COBRA at that time. At the end of the COBRA eligibility period the employee may pay applicable dues directly to Wabash to maintain his / her coverage beginning the first day of the next month, providing that he / she has been an employee of NSC for a period of five (5) years and maintained continuous membership in Wabash during that time.

If an employee is dismissed during the twelve month sick leave waiver of dues period (covered in (c) above), their coverage will continue throughout the hearing process or twelve months whichever comes first.

It is the responsibility of the employee to advise Wabash of the status of their employment, and to keep Wabash informed during the hearing process. If an employee fails to advise Wabash that their dismissal is under appeal, their coverage will terminate the end of the fourth month following the month in which they last rendered compensated service.

- (e) **Off Line:** Employees of NSC who are assigned to off-line points may discontinue their Wabash membership. If they are later transferred to on-line points, they are eligible for reinstatement of membership without a waiting period. Employees at off-line points may also elect to continue their membership while serving off-line and will be covered according to the applicable rules and dues rates.
- (f) **Resigned:** Active employees leaving NSC employment prior to retirement (providing they are not disqualified, on sick leave, furloughed, etc.) who have not been eligible for Wabash benefits as an active employee, but will become eligible as a retiree, may obtain primary coverage through Wabash while awaiting retirement age, subject to the applicable dues rate and a 90 day waiting period from the date the application and first month's dues are received by Wabash.

Eligibility and Participation – Retired Railroaders – Not on Medicare

II. Retirees of the Norfolk Southern Corporation

(a) Eligible Retirees:

- (i) Upon retirement, any Wabash member who is an NSC employee applying for an annuity from the Railroad Retirement Board is eligible for membership in Wabash at the applicable dues rate regardless of prior eligibility. Application for membership must be made within 60 days of retirement. Applications received after the 60 day period will be subject to a 90 day waiting period before coverage will go into effect. Coverage is provided through the Redbird/Redbird Plus benefit schedules.
- (ii) Employees retiring under the 60/30 plan must have five years prior Wabash membership to qualify for company sponsored plan or Wabash upgrade. Coverage is provided through the Bluebird/Banner Blue benefit schedules.

- (b) **Crafts not Participating:** Wabash membership is not available if the craft the employee is presently or formerly represented by is not affiliated with Wabash. Exception is granted to those with at least ten years of membership with Wabash as an active member at the time of membership application.

Eligibility and Participation – Retired Railroaders on Medicare

III. Retired Railroad Employees

Medicare Supplement is available to any retired railroad worker that is Medicare eligible, provided that the railroad worker had 5 years of service with the railroad, regardless of which railroad employed them.

Eligibility and Participation – Non-Railroaders

IV. Employees of Wabash Memorial Hospital Association

(a) Active Wabash Employees: Wabash employees, their spouses, and dependent children under the age of 26 are eligible for membership in Wabash. Applicable dues will be deducted from the employee's paycheck. Dues deducted provide coverage for the current month. Primary coverage will be provided through the Cannonball Plan's Benefit Summary.

(i) Dependents are subject to a 90 day waiting period if they do not enroll at the same time as the employee is hired or if they do not have a qualifying event.

(b) Eligibility After Termination of Employment: Upon termination of employment with Wabash, COBRA coverage is available for the employee and dependents receiving Wabash coverage. At the end of the COBRA eligibility period employees with a minimum of five consecutive years of service with Wabash Memorial Hospital Association and their dependents are eligible to continue their Wabash coverage as defined in section V.

V. Spouses, Dependents, Parents and Parents-In-Law of Wabash Members

(a) Primary Coverage. Primary coverage is available through the Redbird and Redbird Plus benefits schedules to:

- (i) Current spouse or widow(er) of anyone previously employed by the Railroad or Wabash for at least five years who no longer receives coverage through the Railroad Employees National Health and Welfare Plan, another hospital association, or their employer;
- (ii) Adult children aged 26 and over, parents and parents-in-law of a Wabash member that does not have coverage available from their employer, provided that the member has been enrolled in Wabash for no less than 5 years; and
- (iii) Former spouse or dependent child age 26 and over who has been a Wabash member for no less than one year if coverage is not available from their employer.

(b) Secondary Coverage. Secondary Coverage is available through the Piggyback Benefits Summary to the spouse and dependent children under the age of 26 of Wabash members who are active or retired contract or non-contract Railway employees whose primary coverage is provided by the Railroad.

(c) Medicare Supplement Coverage. Medicare Supplement is available through the Medicare Benefit Summary to 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; and
- (ii) Child, parent and parent-in-law of a Wabash member, provided that the member has been enrolled in Wabash no less than 5 years.

(d) Effective Date of Dependent Coverage. Coverage for dependents is effective the first of the month following a 90 day waiting period which begins the date an application and first month's dues are received at Wabash.

Continuing Membership under COBRA

Active NSC and Wabash employees who would lose their membership in the plan because of a "qualifying event" may elect to continue their membership under the provisions of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985.

Qualifying Events: "Qualifying events" are certain events that cause you or your family members to lose coverage through Wabash.

The following qualifying events permit coverage to continue for you and your eligible dependents:

- Termination of your employment for any reason except gross misconduct.
- A reduction in hours worked by you.

The following qualifying events permit coverage to continue for your eligible dependents:

- Your death.
- Divorce or legal separation from your spouse.
- You become entitled to Medicare.

The loss of your dependent child's eligibility is considered a qualifying event for that child. In addition, in certain circumstances, the bankruptcy of your employer is also considered a qualifying event.

Notice of Qualifying Events: Wabash must be notified when a qualifying event occurs. If the qualifying event is your divorce or legal separation or a child's loss of dependent status under the plan, you (or your dependent) must notify Wabash within 60 days, starting from the later of (i) the date the qualifying event occurs; or (ii) the date on which you or your dependent loses (or would lose) coverage

under the plan as a result of the qualifying event. Your employer is responsible for notifying Wabash of all other qualifying events.

Within 14 days after receiving notice of a qualifying event, Wabash will provide the affected member an election notice, which describes his or her right to elect COBRA continuation membership.

To protect your family's rights, let Wabash know about any changes in the addresses of family members. You should also keep a copy for your records, of any notices you send to Wabash.

Election of Continuation Membership: Affected members will then have a 60-day election period to notify Wabash of your decision to elect or waive COBRA continuation membership. The 60-day election period begins on the later of (1) the date the individual would lose regular plan membership because of one of the qualifying events described above or (2) the date the individual is sent a notice of the right to elect continuation membership. If a qualifying member informs Wabash within the 60-day election period of his or her decision to elect continuation membership, continuation membership begins on the date the individual's regular plan membership ends. Individuals electing continuation membership must pay full membership dues (plus a small administrative charge).

If a qualifying member waives continuation membership, he or she may revoke the waiver at any time before the 60-day election period ends. In that case, the continuation membership begins on the date the waiver is revoked. Coverage will not be provided for the period between the date regular plan membership ends and the date the waiver is revoked.

If a qualifying Member dies or becomes legally incapacitated before the 60-day election period ends, then a personal representative has the right to make an election on the qualifying beneficiary's behalf, provided the election is made before the end of the 60-day election period. The period between the date of death or legal incapacity and the date the personal representative is appointed will not be included for purposes of calculating such 60-day period.

If a qualifying member does not choose continuation membership within the 60-day election period, the individual's eligibility for continuation membership will end. If member does not qualify for or select other coverage, membership in the plan ends.

Maximum Period of Continuation Membership: The maximum period of continuation membership depends on the type of qualifying event.

When the qualifying event is a member's termination of employment (for reasons other than gross misconduct) or reduction in hours of work, continuation membership may last for up to **18 months**. For all qualifying events other than a termination of employment or reduction in hours of work, continuation membership may last for up to **36 months**.

The 18-month maximum period of continuation membership may be extended under two circumstances:

1. If a qualifying member is determined to have been disabled under Title II or XVI of the Social

Security Act at the time of the termination or reduction in hours or within the first 60 days of Wabash coverage, then continuation membership may last for up to 29 months, provided that Wabash is notified of the disability determination before the end of the regular 18-month period and within 60 days of the date the determination is made. (A qualifying member must also notify Wabash within 30 days if a final determination is made that the member is no longer disabled under Title II or XVI of the Social Security Act).

2. The 18-month (or 29-month) period of continuation membership may be extended for up to 36 months if a second “qualifying event” (for example, death, divorce or legal separation, or Medicare entitlement) occurs during the 18-month (or 29-month) period, but only for those individuals who were qualifying members in connection with the first qualifying event and are qualifying members at the time of the second qualifying event. For example, if a terminated employee chooses continuation membership for himself and his spouse and the employee dies before the 18-month (or 29-month) period ends, the spouse may elect to receive continuation membership for a total of 36 months. The 36 months would be measured from the date of the employee’s termination of employment. A termination that follows a reduction in hours is not a qualifying event that creates a right to continuation membership.

Termination of Continuation Membership: Continuation membership ends on the earliest of:

- The date the maximum continuation period expires;
- The date the qualifying individual becomes entitled to coverage under Medicare, if the Medicare entitlement date is after the date that the individual elected continuation membership;
- The last period for which payment was made when coverage is cancelled due to non-payment of the required cost;
- The date the Wabash no longer offers a group health plan; or
- The date the qualifying individual becomes covered under any other group health plan that does not exclude or limit coverage for a pre-existing condition the qualifying individual may have.

Once continuation membership terminates for any reason, it cannot be reinstated.

Also, if the member is eligible for and elects an alternative membership described in the preceding sections, the period of alternative membership may be considered part of the COBRA continuation membership. COBRA continuation membership is identical to the coverage which, as of that time, is being provided by Wabash to similarly situated employees whose coverage has not ended because of a qualifying event. If coverage for similarly situated employees change, coverage for COBRA continuation will change as well.

Other Coverage Options: There may be other coverage options besides COBRA available for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation. You can learn more about many of these options at www.healthcare.gov.

For more information about your rights under the Employee Retirement Income Security Act (ERISA),

including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

If you have questions or require additional information concerning this plan or your COBRA continuation rights, contact Wabash at 1501 North Water Street, Decatur, IL 62521 or call (217) 429-5246.

Eligibility and Participation - Other

Active Member Armed Forces: Coverage will terminate on the date you become a full-time active member of the armed forces. Upon your return to active employment, your health coverage will be reinstated and pre-existing conditions and waiting periods are waived.

Family and Medical Leave Act: If you qualify for an approved family or medical leave of absence (as defined in the Family and Medical Leave Act of 1993), eligibility may continue for the duration of the leave if you pay any required dues directly to Wabash. Failure to make payment within 30 days of the due date will result in the termination of coverage. Wabash must have official notification from NSC of any employee being on a Family and Medical Leave. Upon your return to active employment, your health coverage will be reinstated and pre-existing conditions and waiting periods are waived.

Voluntary Termination: 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.

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: Members whose dues are not deducted from their pay and / or remitted under Health and Welfare Agreements will pay dues directly to Wabash. 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.

Benefits

Benefits under this plan will be paid only if Wabash, as the plan's administrator, decides in its discretion that the applicant or claimant is entitled to them.

Healthcare Providers In-Network – Wabash contracts with Blue Cross Blue Shield to provide Preferred Provider Organization (PPO) services for you and your eligible dependents, in an effort to reduce the effect of rising health care costs while providing quality care. Use of providers not in the PPO network may result in a reduction of benefits. You may look up providers in the BCBS network on their website at www.bcbs.com.

Pre-certification Requirement – As a condition to receiving full benefits under the plan, you or your provider must obtain Pre-certification at least 48 hours before you or your covered dependent receive the following services and/or supplies:

- 1. Medical Services – Provider must contact American Health Holding (AHH) by phone at 866-458-4057:**
 - Inpatient Admissions
 - CT, MRI and PET imaging
 - Durable Medical Equipment over \$500
 - Physical Therapy, Speech Therapy, Occupational Therapy
 - Home Health, Hospice Care
 - Chemotherapy
 - Injectable and specialty drugs administered in physician's office

- 2. Mental Health and/or Substance Abuse Services – Provider must contact Med Care Management (MCM) by phone at 800-391-3332:**
 - Inpatient Admissions
 - Residential Health Services
 - Outpatient Therapy

Precertification is not a promise or guarantee that the plan will cover the cost of the services.

Emergency Admissions – If the admission is an emergency, you must notify AHH or MCM within the first 48 hours of admission or, if later, on the first business day following a weekend or holiday admission.

Emergency Care – Most Wabash plans reduce benefits if the medical condition is not deemed life threatening or emergent. Call 911 or seek medical treatment immediately if your condition is life threatening or may result in irreparable harm.

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 must refund the overpayment. If the refund is not received from the member, the amount of the overpayment may 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 provider must refund the overpayment.

Exclusions

The following is a general list of services, supplies, equipment and benefits that are excluded from benefit coverage unless specifically provided under your Benefit Summary. Members should refer to their individual Benefit Summary for additional conditions or contact Wabash 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 or labor management welfare plan or employer organization plan
- Coverage under a governmental program
- Coverage required by statute such as workers' 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

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 that has resulted in a functional defect

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

Drug Testing – Drug screen testing except as may be required for participation in a substance abuse program, for prescription medication purposes, 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/programs/classes

Expenses Exceeding Plan Allowable Charge

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

Extended Care – Long term care at a skilled care facility, sanitarium rest home, nursing home, 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
- 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 Activity/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 – Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine. If services/supplies are determined to be not medically necessary, they are not covered under the plan.

Medical Equipment – Any disposable or convenience medical equipment, appliance or device

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

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, workers' compensation, government or employer liability. The plan is not 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 Items – 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/hot tubs and adaptations to the home

Pharmaceuticals

- Pharmacy consultations
- Medication and supplies that can be purchased over the counter
- Medication without FDA approval for recommended treatment
- 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, costs of copying medical records or generation of correspondence to other parties

Services provided before member is eligible or after member is terminated

Timely Filing – Claims and all claims information required for processing that is not filed within 15 months from the date of service – unless the claims meet a separate contractual requirement (i.e. BCBS PPO-contracted providers)

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 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:

- I. **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:
 - (a) The primary plan with no coordination of benefits provision will be first payor.
 - (b) If the primary payor is not determined by 1. above, the plan covering the person as an active employee will be primary payor.
 - (c) 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.
- II. **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.

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.

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 the excess payment.

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.

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 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.

Claim Filing Deadline: The plan must receive all claims and information required for claim processing within 15 months from the date of service to provide benefit coverage, unless the claims meet a separate contractual requirement (i.e. BCBS PPO-contracted providers).

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
- 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)
- 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 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 future services 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 within:	48 hours after receiving notice of additional information required
You will be notified of the benefit determination within:	72 hours (or 48 hours after you supplied additional information)
If your 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
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 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.

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.

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.

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, notwithstanding the conflict of laws provisions thereof. 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 located in Springfield, Illinois, which is also the jurisdiction in which the plan headquarters are located and the plan is administered. 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.

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 and 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"):

- I. **Action** shall mean any claim, demand, cause of action, lawsuit (actual or threatened), litigation, proceeding pursuant to any workers' 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).

- II. **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).
- III. **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.
- IV. **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.
- V. **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.
- VI. **Plan** shall mean that (or any) welfare benefits plan administered by Wabash (as defined herein) pursuant to ERISA (as defined herein).
- VII. **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.

VIII. 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 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.

IX. 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.

X. 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.

XI. 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.

- I. 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.
- II. 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.
- III. 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.
- IV. 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 or covered person, or
 - On behalf of any incapacitated Claimant or covered person
- V. 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.
- VI. 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.

- VII. 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.
- VIII. 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.
- IX. 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.
- X. 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.
- XI. 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:

- I. 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.
- II. 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.
- III. 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.
- IV. 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.

- V. 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.
- VI. The Claimant shall provide any and all information about the Claimant's illness or injury as requested by the Plan.
- VII. 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.
- VIII. 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.
- IX. 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.
- X. 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.
- XI. 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.
- XII. 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:

- I. 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;

- 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.
- III. 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
- IV. 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
ATTN: 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 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 the 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 provider’s charge and the Allowable Charge. For example, if the provider charge is \$100 and the Allowable Charge 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.

Benefit Summary – The document that describes a high-level overview of the benefits covered by the applicable plan

Co-insurance – Your share of the costs of a covered health care service after the plan payment. Co-insurance is calculated as a percentage (for example, 20%) of the covered Allowable Charge. You pay your deductible (if applicable) plus any co-insurance you owe. For example, if the plan’s Allowable Charge for an office visit is \$100 and you’ve met your deductible, the plan would pay 80% (\$80), and your co-insurance of 20% would be \$20.

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 services before the plan begins to pay

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

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 or crutches.

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, diagnose or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine

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

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

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 Limit – The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, co-insurance and co-payments (if applicable), the plan pays 100% of the costs of covered benefits. 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

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

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

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

Provider – An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility or rehabilitation center. The plan may require the provider to be 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 Care – Services performed or supervised by licensed nurse in your home or in a nursing home. Skilled nursing care is not the same as “skilled care services”, which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

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 Allowable Charge.

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