GEORGIA CONSUMER-DIRECTED PROGRAMS

EMPLOYEE BENEFITS

ASI RELIANCE HEALTH CARE ENROLLMENT PACKAGE

- ☐ ASI RELIANCE HEALTH CARE ENROLLMENT FORM
- ☐ ASI RELIANCE HEALTH CARE LIFE EVENT CHANGE FORM
- ☐ ASI RELIANCE HEALTH PLAN EMPLOYEE BROCHURE
- ☐ ASI RELIANCE HEALTH CARE SUMMARY PLAN DESCRIPTION

ASI Works Incentive Services, Inc.

BasicCare Program
BasicAdvantage Plan

Enrollment Form

You must complete Sections A and B. Complete Section C only if you are enrolling dependents. Make a copy of your completed Enrollment Form for your records. Please print neatly and firmly within the boxes.

SECTION A — INFORMATION ABOUT YOU

Social Security Number | First Name | Middle Initial | Last Name

Mailing Address: Street | City

State | Zip | Home Phone Number | Birth Date: Month Day Year | Sex: ☐ M ☐ F

Name of Employer: ADMIN SERV INC | Work Phone Number

SECTION B — ENROLLMENT SELECTION

It is important that you follow the directions when making your elections; otherwise, your enrollment may be delayed. And if you are enrolling any of your dependents (spouse or children), please be sure to include their information in Section C; otherwise, their enrollment may be delayed. Costs listed below are **monthly** amounts.

Make your selection by putting an [X] in the box next to the selection you want. Note: You must mark a box in each section.

MEDICAL PLAN (List Dependents on back)			**TERM LIFE / STD PLANS*** (List Dependents on back)		
Employee Only	☐	$ 118.13	Employee Only	☐	$ 18.42
Employee + Spouse	☐	$ 249.25			
Employee + One Child	☐	$ 177.19			
Employee + Children	☐	$ 298.87			
Employee + Family	☐	$ 396.93	Employee + Family	☐	$ 19.28
None	☐		None	☐	

* STD Coverage is only available for employees (no dependent coverage) and is not available for employees who work in CA, HI, NJ, NY, RI, or Puerto Rico. The **monthly** costs for Term Life only are: **$3.25** for Employee Only, or **$4.12** for Employee + Family coverage.

I wish to participate in the benefit plan(s) that I've selected above and I authorize my employer to deduct the required costs from my paycheck. I understand and agree that any Term Life Plan benefits payable upon my death will be paid in equal shares to members of the first surviving beneficiary class, as follows: spouse; children; parents; brothers and sisters; or, if none, then my estate.

Your Signature

Today's Date: Month Day Year

(OVER PLEASE)

Life Event Change Form

Directions:

1. Complete Sections 1, 2, 3, and 4.
2. If you are changing dependent coverage, you must complete section 5.
3. Sign and Date the form.
4. Mail or Fax your completed form as directed on the back of this form.

Please note that if you fail to provide notification within 31 days of a qualified life event, you may not be able to enroll yourself or your dependents, or change your current elections unless there is an Open Enrollment Period.

1. EMPLOYEE INFORMATION

Name:	*Social Security #:*	*Date of Birth:*
Address:	*Daytime Phone #:*	*Evening Phone #:*
City: *State:*	*Zip:*	

2. LIFE EVENT (please check ✓)

☐	Address Change Only	☐	Birth or Adoption of Child
☐	Marriage	☐	Child Eligible (Foster Child / Court Order)
☐	Divorce / Legal Separation	☐	Child Now Ineligible (Child Reaching Limiting Age)
☐	Death of Dependent	☐	Loss of Other Health Coverage

3. DATE OF LIFE EVENT

Month:	*Day:*	*Year:*

4. NEW ENROLLMENT or CHANGES to CURRENT COVERAGE: Costs listed as Monthly (please check ✓)

	Medical Plan	Term Life / STD Plans*
Yourself Only	☐ $118.13	☐ $18.42
Yourself and Spouse	☐ $249.25	N/A
Yourself and One Child	☐ $177.19	N/A
Yourself and Children	☐ $298.87	N/A
Yourself and Family	☐ $396.93	☐ $19.28
None (no coverage)	☐	☐

*STD Coverage is only available for employees (no dependent coverage) and is not available for employees who work in CA, HI, NJ, NY, RI or Puerto Rico. The monthly costs for Term Life only are: $3.25 for Yourself Only or $4.12 for Yourself and Family coverage.

(over)

Information on Dependent(s) to be added or deleted under the following Plan(s):

5. DEPENDENT INFORMATION Change my dependent(s) coverage as follows: (please check ✓)

Add	Delete	Name (first and last)	Relationship (spouse/child)	Date of Birth (mm/dd/yyyy)	SSN	Gender (m/f)	Medical	Term Life
☐	☐						☐	☐
☐	☐						☐	☐
☐	☐						☐	☐
☐	☐						☐	☐
☐	☐						☐	☐
☐	☐						☐	☐

I hereby declare that the information that I provided on this form is accurate and complete. I wish to participate in the benefit plan(s) that I've selected above and I authorize my employer to deduct the necessary contributions from my paycheck. I understand and agree that any Term Life Plan benefits payable upon my death will be paid in equal shares to members of the first surviving beneficiary class, as follows: spouse; children; parents; brothers and sisters; or, if none, then my estate.

Employee Signature Date

Please complete this form, sign/date, and mail or fax to:

Administrative Services, Inc.
Attn: Melvin Williams
7101 Wisconsin Ave, Suite 1400
Bethesda, MD 20814

Fax: 301-654-0230

RESERVED FOR RSL ADMINISTRATOR
Date Received:

Reliance Standard Life Insurance Company
BasicCare Program

BasicAdvantage Plan
Employee Brochure

Important protection for You and Your dependents …
made available by your employer ... through easy payroll deduction.

Your acceptance is Guaranteed — you cannot be turned down,
as long as you sign-up during your open enrollment period.

Medical

This is not a comprehensive major medical plan, nor is it intended to replace a major medical plan. The plan is intended to provide you, and your covered dependents, with basic insurance coverage.

- Visit any doctor or hospital.
- Enrolled dependents receive the same coverage as you.
- No pre-existing conditions exclusions or limitations.
- Medical Plan enrollees also receive these added non-insurance benefits:
  - Prescription Drug Card offering discounts at participating pharmacies.
  - VSP Access Plan membership offering discounts on eye exams and prescription glasses at network doctors.
  - 24-Hour Nurse Hotline.
  - On-line Wellness Assistance.
  - Vitamins & Nutritional Supplements Plan.
  - On Call Travel Assistance.

INPATIENT HOSPITAL BENEFITS	
Daily Room & Board Benefits:	
Daily Benefit for the Treatment of Mental & Nervous Conditions	$100 Per Day
Maximum Number of Days Per Coverage Year for the Treatment of Mental & Nervous Conditions	25
Daily Benefit for the Treatment of Alcohol & Substance Abuse	$100 Per Day
Maximum Number of Days Per Coverage Year for the Treatment of Alcohol & Substance Abuse	25
Daily Benefit for the Treatment of All Other Covered Conditions	$400 Per Day
Maximum Number of Days Per Coverage Year for the Treatment of All Other Covered Conditions	90
Hospital Admission Benefit For Specified Conditions:	
Cancer (Malignant Neoplasm)	$4,000
Maximum Number of Admissions Per Coverage Year	1
Heart Attack (Myocardial Infarction) or	$3,000
Heart Disease[1]	$1,500
Maximum Number of Admissions for All Such Conditions Per Coverage Year	1
Accidental Injury	$2,000
Maximum Number of Admissions Per Coverage Year	1
Stroke (Cerebrovascular Accident - CVA)	$1,500
Maximum Number of Admissions Per Coverage Year	1
Childbirth	$1,500
Maximum Number of Admissions Per Coverage Year	1
Maximum Surgery Benefit Per Procedure[2]	$1,000
Maximum Anesthesia Benefit[3]	$200

[1] The Hospital Admission Benefit is payable for either Heart Attack or Heart Disease during a coverage year, but not both.

[2] Benefits for covered inpatient surgery are scheduled and range from $18 to $1,000 based on the specific surgical procedure performed.

[3] Benefits for covered inpatient anesthesia vary and are equal to 20% of the applicable inpatient surgery benefit.

OUTPATIENT BENEFITS	
Doctor Visit Benefits:	
New Patient Office Visit	$75 Per Visit
Maximum Number of Visits Per Coverage Year	1
Established Patient Office Visit	$70 Per Visit
Maximum Number of Visits Per Coverage Year	3
Consultation Office Visit	$100 Per Visit
Maximum Number of Visits Per Coverage Year	1
Emergency Room Doctor Visit	$75 Per Visit
Maximum Number of Visits Per Coverage Year	1
Radiology Benefits:	
Magnetic Resonance Imaging (MRI)	$150 Per Visit
Maximum Number of Visits Per Coverage Year	1
Computerized Tomography (CT) Scan	$75 Per Visit
Maximum Number of Visits Per Coverage Year	1
All Other Radiology Services	$40 Per Visit
Maximum Number of Visits Per Coverage Year	5
Pathology Benefits:	
All Pathology Services	$40 Per Visit
Maximum Number of Visits Per Coverage Year	5
Wellness Care Visit Benefits:	
Annual Physical	$75 Per Visit
Maximum Number of Visits Per Coverage Year	1
Mammogram Screening	$50 Per Visit
Maximum Number of Visits Per Coverage Year	1
Prostate or Cervical Cancer Screening	$35 Per Visit
Maximum Number of Visits Per Coverage Year	1
Emergency Room Visit Benefits:	
Treatment of an Accidental Injury	$500 Per Visit
Maximum Number of Visits Per Coverage Year	2
Treatment of a Sickness	$50 Per Visit
Maximum Number of Visits Per Coverage Year	3
Maximum Surgery Benefit Per Procedure[4]	$1,000
Maximum Anesthesia Benefit[5]	$200
Prescription Drug Benefits:	
Generic Drug Maximum Amount Per Prescription	$25
Generic Drug Maximum Number of Prescriptions Per Coverage Year	18

[4] Benefits for covered outpatient surgery are scheduled and range from $32 to $1,000 based on the specific surgical procedure performed.

[5] Benefits for covered outpatient anesthesia vary and are equal to 20% of the applicable outpatient surgery benefit.

Term Life with Accidental Death Benefit

- Plan provides $10,000 of term life coverage for you, with an additional matching $10,000 in the event of accidental death.
- Your benefits reduce by 50% when you reach age 70.
- Your benefits will be paid in equal shares to members of the first surviving beneficiary class, as follows: spouse; children; parents; brothers and sisters; or, if none, your estate.
- If you sign up for this benefit, you can add term life coverage for your spouse and each child (older than 6 months) in the amount of $2,500. Coverage amount for children 6 months of age or younger is $500.
- Spouse coverage ends at age 70.
- You are the beneficiary for spouse and child term life coverage.
- Term life benefits are not payable for death during the first 2 years of coverage if due to suicide or attempted suicide.

Short-Term Disability*

- Plan provides weekly benefits for up to 26 weeks of disability. The amount paid is 50% of base pay, up to a maximum of $125 per week.
- Disability must be due to a sickness or an injury from an accident that happens while you are covered. You must become totally disabled while covered and, if due to an injury, within 90 days of the date of the accident.
- If you are hospitalized, the benefits are payable immediately; otherwise, the benefits begin after a 14-day elimination period.
- Benefits reduce by 50% when you reach age 70.

* STD coverage is only available to you. There is no dependent coverage available.

Questions & Answers

Who can be covered? In addition to covering yourself, dependent coverage is offered in the medical and term life plans. Your eligible dependents are your lawful spouse and your children through age 25, or through any age if handicapped and unable to earn a living.

When does my coverage begin and end? Your coverage begins on the first day of the month after you enroll, provided you are eligible and the required premium has been paid. Coverage for all of your benefits under the program will end if (1) the required premiums are not paid; (2) you are no longer an eligible employee; (3) the insurance policies terminate; or (4) you enter an Armed Service on full-time active duty.

When does dependent coverage begin and end? Your dependents' coverage begins when yours does, unless you enroll them later. If you do, their coverage will become effective after the written enrollment is approved and the premiums have been paid. Their coverage ends when yours does or when the dependent is no longer eligible.

Do I have to use certain doctors or hospitals? No. You are free to use any licensed doctor or any certified hospital. However, under the medical plan, you can save money by using a network provider. Rest, nursing or old age homes, or facilities for the treatment of alcoholism, drug addiction or mental disorders are not hospitals.

How does the Hospital Admission Benefit work? It pays a lump sum benefit when you are admitted as an inpatient to the hospital for treatment of any of the conditions shown. The benefit amount varies by condition and is payable based on the first diagnosis code listed on the claim form for the hospital admission.

When will I receive ID cards and full coverage information? You will receive a Summary Plan Description after you enroll. ID cards will be included.

Does the medical plan cover maternity? Yes. Maternity is a covered expense.

Are visits to a chiropractor covered under the medical plan? Yes, chiropractic office visits are covered; however, chiropractic adjustments, manipulations, or modalities are not covered.

Exclusions & Limitations

The following is just a summary. Please see your Summary Plan Description (SPD) for a more complete description of these items.

What is not covered under the Medical Plan...

- outpatient treatment of mental or nervous conditions;
- outpatient treatment of alcoholism, or substance abuse;
- intentionally self-inflicted injuries, suicide, or any attempt thereat while sane or insane;
- acts of declared or undeclared war;
- the covered person's commission of a felony;
- work-related injury or sickness;
- eye examinations for glasses, any kind of eye glasses, or prescriptions therefore;
- hearing examinations or hearing aids;
- brand name drugs and drugs not requiring a prescription;
- dental care or treatment other than care of sound, natural teeth and gums required on account of an accidental injury that happens while covered, and rendered within 6 months of the accident;
- reading or interpreting the results of any diagnostic pathology or radiology tests;
- cosmetic surgery, except covered services rendered in connection with cosmetic surgery needed for breast reconstruction following a mastectomy or an accident that happens while covered. The surgery needed for an accident must be performed within 90 days of the accident; and
- services provided by a member of a covered person's immediate family or services provided by your employer.

What is not covered under Short-Term Disability and Accidental Death benefits...

- suicide or attempted suicide, or any intentionally self-inflicted injuries, while sane or insane;
- acts of war (declared or undeclared);
- your commission or attempted commission of a felony;
- your operating, riding in, or descending from any aircraft, other than while a fare-paying passenger on a licensed, commercial, non-military aircraft;
- voluntarily taking poison, gas, drugs, or chemicals not prescribed by a physician;
- release of nuclear energy;
- participation in a riot or an illegal occupation;
- Short-Term Disability benefits are not paid for an injury or sickness related to your work; and
- Accidental Death benefits are not paid for death resulting from sickness of any kind.

The Short-Term Disability benefit is not available to persons who work in California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico due to statutory coverage. In these states (and Puerto Rico), the employer is required to provide a disability benefit.

The Medical Plan and Term Life (with Accidental Death) and Short-Term Disability Plans are underwritten by Reliance Standard Life Insurance Company, Philadelphia, Pennsylvania under group policy form series: LRS-9169-1103, et al and LRS-9222-0205, et al; and LRS-9173-1103, et al, respectively.

Refer to the accompanying materials for information on premiums.

Every effort has been made to ensure the accuracy of this enrollment brochure. The information described applies to the residents of most states, however state laws do vary. The laws of your state may affect this benefit program, but these differences generally do not reduce your benefits. This brochure is not a legal document. The contractual terms and conditions of coverage are set forth in the group policies. In the event of a discrepancy, the policies would be the determining factor. Insurance products are provided through Reliance Standard Life Insurance Company, which is licensed in all states (except New York), the District of Columbia, Puerto Rico, & the U.S. Virgin Islands. Reliance Standard Life Insurance Company reserves the right to change the premiums it charges for its plans.

VSP Access Plan discounts from Vision Service Plan. 24-hour Nurse Hotline, Online Wellness Services and Nutritional Supplements Plan from Coverdell and Company, Inc. On Call Travel Assistance from On Call International. The suppliers of these services are not affiliated with Reliance Standard Life Insurance Company, which is not responsible for the content of the services and cannot be held liable for any services provided or not provided by these suppliers.

SUMMARY PLAN DESCRIPTION (SPD)

of the **Administrative Services, Inc. BasicCare Program**

(the "Benefit Program")

This booklet provides important information about the Benefit Program offered by your Employer.

PLEASE NOTE: A person can only be covered if eligible for the coverage; if enrolled; and if the required premium has been paid. If you have any questions about your enrollment status, please contact your Employer.

This booklet, together with the copy of the form used to enroll, makes up the Summary Plan Description.

TABLE OF CONTENTS

BENEFIT PROGRAM INFORMATION

Carrier:	Reliance Standard Life Insurance Company
Carrier's Address:	2001 Market Street, Suite 1500, Philadelphia, PA 19103
IMPORTANT FACTS ABOUT THE BENEFIT PROGRAM	
Eligible Employees:	All employees.
Eligibility:	The first day of the month following date of hire.
Coverage Begins:	The first day of the month following your enrollment provided you are eligible and the required premium is paid.
Coverage Year Begins:	June 1
ERISA INFORMATION	
ERISA Plan Name:	Administrative Services, Inc. BasicCare Program
Type of ERISA Plan:	Health and Welfare Benefits
ERISA Plan Number:	As on file with the ERISA Plan Administrator
ERISA Plan Fiscal Year End:	As on file with the ERISA Plan Administrator
ERISA Plan Sponsor:	Administrative Services, Inc.
ERISA Plan Administrator:	Melvin Williams Vice President / Human Resources 7101 Wisconsin Ave, Ste. 1400 Bethesda, MD 20814 Phone: (301) 654-3903 Fax: (301) 654-0230
Agent for Service:	ERISA Plan Administrator
Employer Identification #:	52-2052647

The terms and conditions of the benefits described in this booklet apply to most states; however, state laws do vary. The laws of the state in which the carrier issues the group policies may affect this Benefit Program. These differences generally do not reduce your benefits. For more information regarding any changes in your coverage because of these variances, please see the next page.

Questions?
Just call RSL Specialty Products Administration at 1-866-375-0775. Representatives are ready to answer your coverage questions Monday through Friday, from 8:30 am to 5:30 pm, ET.

Preguntas? Este folleto contiene un resumen en ingles de su Programa de Beneficios de Grupo. Si usted tiene dificultad en entender cualquier parte, llame al numero gratuito 1-866-375-0775. Representantes de consulta estan disponibles lunes a viernes, de 8:30 am a 5:30 pm (hora del Este), para darle asistencia en espanol.

ID CARDS

Please Remember:

- ID Cards are only valid if 1) you have enrolled AND 2) your first premium has been paid.
- If you have elected Medical Coverage, your Medical ID Card should be in the same package that included this booklet. A separate Prescription Drug ID Card will arrive shortly after your first premium has been paid for Medical Coverage. The VSP Access Plan Membership Card is included below.
- Carry your ID Card(s) with you when you visit a health care provider. Information on the card(s) will help the provider to file a claim for you.
- ID Cards are not proof of coverage under any plan.
- ID Cards become void if your coverage is terminated.

IF YOU HAVE ENROLLED FOR MEDICAL COVERAGE, CUT OUT THE VSP ACCESS PLAN MEMBERSHIP CARD AND KEEP IN YOUR WALLET.

VSP Access PLAN

VSP

As a VSP member, you'll receive the following Access Plan discounts from a VSP network doctor:

- 20% discount on your eye exam
- 20% discount on your frame, lenses and lens options when a complete pair of prescription glasses is purchased
- 15% discount on your contact lens exam (fitting & evaluation)
- Discounts on laser vision correction

These discounts are only available from the VSP network doctor who provided your eye exam within the past 12 months.

Questions? Visit our Web site at vsp.com or
4/04 Call VSP at 800-877-7195 00195

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STATE OF MARYLAND REQUIREMENTS

The group insurance policies that provide the insurance benefits of the Benefit Program are issued in the state of Maryland, which requires the following changes to the noted sections.

General Questions:

1. The description of eligible dependents is expanded to include:

   - your unmarried grandchild who is in your court-ordered custody, who resides with and is dependent upon you, and who is less than age 26; and
   - an unmarried individual who is under your testamentary or your court appointed guardianship (other than temporary guardianship of less than 12 months duration), who is dependent upon you, and who is less than age 26.

2. The description of when your dependents' coverage begins and ends is changed to read as follows:

   Your dependents' coverage begins when your coverage begins if you enrolled them when you enrolled. It ends when yours does, or when the dependent is no longer eligible. If you've enrolled in the Medical Coverage, your child born while coverage is in force is covered for injury and sickness (including necessary care and treatment of congenital defects, birth abnormality and premature birth), as well as routine newborn care for the first 31 days. The child will remain covered for injury and sickness after the first 31 days only if you apply for coverage and pay any required premium within the 31-day period after the child's birth. A minor child who comes under your care and control while the Medical Coverage is in force is covered for injury and sickness provided you file a petition to adopt. The child will be covered from the date the petition to adopt is filed if you apply for coverage and pay any required premium within 30 days after filing the adoption petition. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 30 days after the child's birth. The carrier reserves the right to approve or disapprove any late application to cover a dependent.

Medical Coverage:

1. The hospital daily room & board benefits for the treatment of alcohol & substance abuse will be paid on the same basis as hospital daily room & board benefits are paid for all other covered conditions.

2. The description of an injury is changed to:

   Injury is a covered person's bodily injury caused by an accident that results, directly and independently of all other causes, in a covered loss; including a covered loss resulting from terrorism. All injuries sustained in one accident, including all related conditions and recurring symptoms of the injuries, will be considered one injury.

3. The description of a sickness is changed to:

   Sickness is a covered person's sickness or disease that results, directly and independently of all other causes, in a covered loss; including a covered loss resulting from terrorism.

4. The exclusion for outpatient treatment of alcoholism or substance abuse does not apply.

5. The exclusion regarding a covered person's commission of a felony does not apply.

Term Life Coverage:

The accidental death benefit exclusion for the release of nuclear energy does not apply.

Short-Term Disability Coverage:

1. The requirement that the accident must happen while you are covered does not apply; instead, total disability due to an injury must begin while you are covered.

2. The requirement that total disability due to an injury must occur within 90 days of the accident does not apply.

3. The exclusion for participation in a riot does not apply.

4. The exclusion for the release of nuclear energy does not apply.

GENERAL QUESTIONS

Can I change my enrollment choices?

Not usually. Typically you must wait for the next open enrollment period. However, there are certain times when enrollment changes can be made.

If you didn't enroll in Medical Coverage because you and/or your dependents were already covered under another plan, and that coverage is lost, you can request a special enrollment within 31 days of the loss of that other coverage.

Reasons for losing other medical coverage:

- Divorce, legal separation, or death;
- Termination of a dependent's employment;
- Reduction of a dependent's hours;
- Termination of COBRA rights; or
- Loss of employer's contribution to spouse's medical coverage.

If you have a change in your family situation, such as a divorce, legal separation, death, marriage, or birth/adoption of a child, you can request a special enrollment within 31 days of that change.

YOU MUST COMPLETE A LIFE EVENT CHANGE FORM to make any enrollment change. That form is available from your Employer.

When will coverage end?

Coverage ends if:

- premiums aren't paid in full;
- you enter an Armed Service on full-time active duty;
- you are no longer eligible for the coverage; or
- the group policies terminate.

If coverage ends, you may be entitled to continue your coverage under COBRA. There is information about COBRA later in this booklet.

How much does the Benefit Program cost?

The premium due for the Benefit Program varies depending upon the coverage you selected and which family members you cover. You should check your copy of the form you used to enroll to determine the amount due for your coverage.

Note: Premium amounts are subject to change over time.

Who is an eligible dependent?

If the Benefit Program allows for dependents to be covered, eligible dependents are:

- your lawful spouse; and
- your children through age 25.

Eligible children include your children by birth, stepchildren, foster children, legally adopted children, children living with you while you are completing adoption procedures, and children for whom coverage has been court-ordered.

Note: If you have a covered child who turns 26 and is handicapped and unable to earn a living, they may still be eligible for coverage. You must notify your Employer within 31 days to ensure continued eligibility for that child. Proof of continued eligibility may be required from time to time.

When does coverage begin and end for my dependents?

Your dependents' coverage begins when your coverage begins if you enrolled them when you enrolled. It ends when yours does, or when the dependent is no longer eligible. If you've enrolled in the Medical Coverage, your child born while coverage is in force is covered for injury and sickness (including necessary care and treatment of congenital defects, birth abnormality and premature birth), as well as routine newborn care for the first 31 days. The child will remain covered for injury and sickness after the first 31 days only if you apply for coverage and pay any required premium within the 31-day period after the child's birth. A minor child who comes under your care and control while the Medical Coverage is in force is covered for injury and sickness provided you file a petition to adopt. The child will be covered from the date of placement in your home if you apply for coverage and pay any required premium within 31 days after the date of placement. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. The carrier reserves the right to approve or disapprove any late application to cover a dependent.

If a court order requires that I provide coverage for my dependents, how will this begin?

You and your Employer will both receive the court order requiring coverage to begin for your dependents. Your Employer will then be responsible for making the appropriate arrangements and notifying the carrier.

What if both my spouse and I work for the same Employer?

You can either both choose single coverage or one of you may choose family coverage. You may not be covered twice. If you and your spouse have one or more eligible children, only one of you may cover all dependents (spouse and children).

PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

RELIANCE STANDARD LIFE INSURANCE COMPANY
FIRST RELIANCE STANDARD LIFE INSURANCE COMPANY
RELIANCE STANDARD LIFE INSURANCE COMPANY OF TEXAS

PRIVACY NOTICE

The Reliance Standard Life Insurance group of companies recognizes that protecting the privacy and security of the personal information we obtain about our customers is an important responsibility. This Privacy Notice generally describes our policy about how we treat that information. This notice refers to Reliance Standard Life Insurance Company, First Reliance Standard Life Insurance Company and Reliance Standard Life Insurance Company of Texas using the terms "we," "us," and "our."

Information we may obtain. Depending on the type of product or service that we are providing, we may obtain Customer Information, Financial Information and/or Health Information about you.

Customer Information includes identifying information such as your name, address, telephone number, Social Security number and demographic data about you. It also includes information about your transactions with us such as the type and value of the Reliance Standard products you own and the amount of premiums and fees that you pay to us.

Financial Information includes information about your income, assets, liabilities, and the type and value of other insurance that covers you.

Health Information includes information about your health and medical history and your insurance underwriting risk factors.

Security of the information. We maintain physical, electronic and procedural safeguards that comply with Federal and State laws to protect all of the information we have obtained about you.

From whom we obtain information. We may obtain Customer Information, Financial Information and/or Health Information from any of the following sources:

- Your application and related forms;
- Your insurance agent or broker;
- Your communications with us;
- Your employer;
- Your medical providers;
- Consumer reporting agencies;
- Your claim for benefits; and
- Anyone you have authorized to provide information to us.

What we do with the information we obtain. The Customer Information, Financial Information and Health Information (collectively referred to here as "Information") which we obtain is used in order to provide our products and services to you, and may be used to evaluate your request for products or services, evaluate your claim for benefits and process your transactions with us. We may also use the Information to offer you other products and services which we or our affiliated companies (that is, members of the Delphi Financial group of companies) provide. The Information may be disclosed to non-affiliated entities with whom we have contracted to perform certain business services for us. This may include entities which provide claims administration, underwriting, investigation, reinsurance, policyholder or other services to us or on our behalf. These companies are carefully selected, and are required by the terms of their contract with us to maintain the confidentiality of the Information. We may also disclose Information about you if you have authorized us to do so, or as otherwise permitted or required by law.

We do not disclose any nonpublic personal information about you to any non-affiliated company for marketing purposes or for any other purpose except as described in the previous paragraph.

Independent Sales Agents. Your policy may have been placed with us through an independent agent or broker ("Sales Agent"). Your Sales Agent may gather and retain Information about you. The use and protection of Information by your Sales Agent is your Sales Agent's responsibility, not our responsibility. If you have questions about whether or how your Sales Agent uses or discloses such information, please contact your Sales Agent.

totally disabled, your benefits will cease. If you have several periods of total disability due to the same or related causes, and they are separated by less than 2 straight weeks of work (at your regular schedule), the STD Coverage will treat this as one period.

EXCLUSIONS AND LIMITATIONS

No benefits will be paid for a disability caused by or resulting from:

- Work-related injury or sickness, whether or not benefits are payable under Workers' Compensation or similar law;
- Attempted suicide or intentionally self-inflicted injury, while sane or insane;
- Voluntarily taking poison, inhaling gas, or taking a drug or chemical not administered by a physician;
- War or any act of war, whether declared or not;
- Your commission of, or attempt to commit, a felony, or any loss sustained while incarcerated for the felony;
- Your participation in a riot;
- Your engaging in an illegal occupation;
- Release of nuclear energy; and
- Your operating, riding in, or descending from any aircraft (including a hang glider), other than while a passenger on a licensed, commercial, non-military aircraft.

AVAILABILITY

If you work in California, Hawaii, New Jersey, New York, Rhode Island, or Puerto Rico, STD coverage is not available.

FILING A CLAIM

How do I file a claim?

If you become totally disabled while covered under the STD Coverage you should apply for the insurance benefit as soon as possible. You may request a claim form from your Employer or you may call RSL Specialty Products Customer Service at 1-866-375-0775. Be sure to have your Employer complete their part of the claim form and have your doctor complete their part of the claim form including the dates of disability. Claims should be mailed to: RSL Specialty Products Administration, Claims Department, 505 S. Lenola Road, Suite 231, Moorestown, NJ 08057. Claims must be submitted within one year of the date of the loss. The carrier reserves the right to require a medical examination at its expense. For Claims Customer Service, call 1-866-375-0775, Monday through Friday, 8:30 a.m. to 5:30 p.m., ET.

When will I know if my claim is denied?

If all or a part of your claim is denied, you will be notified in writing within 45 days from the date your claim was received. Under some circumstances, the carrier can notify you that it is extending this 45-day time frame by an additional 30 days. The denial notice will include: (a) the specific reason(s) for the denial; (b) the specific policy provision(s) on which the decision is based; (c) a description of any information needed to make the claim complete; (d) a statement of your right to review (on request and at no charge) relevant internal guidelines, documents, and other information; and (e) an explanation of how to appeal for reconsideration of the decision. If you are required to submit additional information to support your claim, you will have 45 days to do so.

How do I appeal a denied claim?

If you disagree with the decision, you may request a review within 180 days of the initial denial. If you do not submit your appeal on time, you generally will lose the right to appeal the denial. Your appeal must be in writing, clearly stating the reason you believe the denial is incorrect, and include any additional documentation that you feel would support a further review of your claim. You (on request and at no charge) may have reasonable access to and receive copies of all relevant documents concerning your claim. The reviewer of your appeal will be a different person or persons from the reviewer of your initial claim and will not be a subordinate of the initial reviewer. Your claim will be reviewed and a decision will be issued within 45 days from the date your appeal was received. Under some circumstances, the carrier can notify you that it is extending this 45-day time frame by an additional 45 days. If the decision on appeal continues to deny your claim, you will be furnished with a notice of adverse benefit determination on review, setting forth: (a) the specific reason(s) for the denial; (b) the specific policy provision(s) on which the decision is based; (c) a statement of your right to review (on request and at no charge) relevant internal guidelines, documents, and other information; and (d) a statement of your right to bring a lawsuit.

What if I miss a deadline for filing a claim or appealing?

If you do not submit your claim on time, do not appeal on time, or do not otherwise follow the claims procedures, you may lose the right to file suit in court because you may have failed to exhaust your internal administrative appeals rights, which may be a prerequisite to bringing suit.

COBRA – EXTENDED COVERAGE

What is COBRA?

As noted previously, if your coverage ends you may be entitled to have continued coverage in some circumstances. A federal law known as COBRA gives you this continuation right. It stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. The continuation right only extends to the Medical Coverage.

While you may elect COBRA continuation coverage on behalf of your dependents, each person who was covered at the time coverage ends has his or her own right to elect COBRA and/or any other state continuation or conversion rights. This means that your dependents may elect such coverage even if you decide not to. So, if you have enrolled your eligible spouse or children, please share this information with them. If you would like additional copies of this booklet to share with your spouse or children, please contact your Employer. For more information about your COBRA rights, contact your Employer.

When am I eligible for COBRA?

You and your covered dependents are eligible for COBRA continuation if you lose coverage because you quit or lose your job for any reason, other than gross misconduct, or your hours are reduced. Generally, you and your dependents are entitled to continue health coverage for 18 months. However, if you or your dependents are disabled, then the period may be extended to a total term of 29 months (see "What if I am disabled when my employment ends?").

What about my dependents?

Your dependents are also eligible for COBRA continuation if they lose coverage at any time due to:

- your death;
- your divorce or legal separation;
- your becoming entitled to Medicare while on COBRA; or
- your dependent no longer meeting the eligibility definition under the Benefit Program (for example, a dependent child reaching the age limit).

In any of these qualifying events your dependents are entitled to continue health coverage for 36 months from the date of the event.

What must I do to elect COBRA?

Your Employer must provide notice when you lose or quit your job, your hours are reduced, or you become entitled to Medicare. Your Employer will notify you of your right to elect COBRA. Within 60 days of that notification, you must respond, in writing, of your election. Do not send a payment with your election.

When will I pay for COBRA coverage?

Once your election is received, you will be notified by mail of the amount of your first premium and where to send your payment. You will have 45 days from your election to make your initial premium payment. This first premium payment will retroactively cover the period from your coverage termination date to the date of your election. After that, the regular monthly payments (shown on your initial notice) are due by the first of each month. No bills or reminder notices will be sent to you.

Do my dependents and I have to keep my Employer informed?

Yes. You and your dependents must notify your Employer of your current address and, if different, the address(es) of your dependents (spouse and children). You and/or your dependents must provide notice of: (1) your divorce or legal separation; (2) your dependent's loss of coverage for any of the reasons previously listed (see "What about my dependents?"); and (3) a determination by the Social Security Administration that you or your covered dependents are disabled. You and your dependents must mail or hand-deliver written notice of these events within 60 days to your Employer.

When does COBRA end?

COBRA coverage will end on the earliest of:

- the expiration of the maximum allowable term of 18, 29 or 36 months;
- the date the required premium is not paid when due;
- the date the group health coverage is terminated for active employees;
- the date the person on COBRA coverage first becomes covered under any other group health plan, without limitation as to any pre-existing condition that affects coverage; or
- the date the person on COBRA coverage becomes entitled to Medicare benefits.

What if I am on extended sick leave when my employment ends?

Under the federal Family and Medical Leave Act of 1993 (FMLA), you may be entitled to extended sick leave from your employment. If during that period you do not pay your premium, you can still elect COBRA if your employment ends during your FMLA leave. In such a case, you would not have to make up the missed premium for any time when you were on FMLA leave, but you would not be covered for any gaps in coverage.

What if I am disabled when my employment ends?

In order to extend continuation coverage for you and your dependents to 29 months, you or a covered family member must be disabled before or within the first 60 days of COBRA coverage. If this is the case, a copy of the

Social Security Administration's "determination of disability" must be sent to your Employer within 60 days of the determination, and within the original 18 months of your COBRA coverage. The premium to be paid for this additional 11 months of coverage may be substantially greater than the premium for the initial 18-month period and you will be notified of the additional cost of the extended coverage. If, during the 11-month extension, you or your covered dependents are no longer disabled, you must notify your Employer within 30 days. The extended COBRA coverage will end when you or your dependent are no longer disabled.

Is there another way to extend COBRA coverage?

Yes. If, while under the initial 18-month COBRA continuation coverage, your covered dependents experience another event that separately entitled them to COBRA continuation, they may get up to 18 additional months of continuation coverage. Notice of the second qualifying event must be given to your Employer. This extension is available only if the event would have caused the dependent to lose coverage under the Benefit Program had the first loss of coverage not occurred.

What premium has to be paid for COBRA coverage?

Generally, you will pay the rate for active employees under the Benefit Program, plus a 2% administrative fee. If the rate changes for active employees, your rate will change accordingly. As noted above, the premium for the 11-month extension because of disability could be substantially higher than normal.

What rights does a person on COBRA have during an open enrollment period?

A person on COBRA has the same rights at open enrollment as any other covered person under the Benefit Program.

Is there a way, other than COBRA, to extend coverage?

In some limited circumstances, and as governed by state law, you may be entitled to extended coverage if you lose your coverage and do not elect COBRA. At such time, you should contact your Employer to determine what rights, if any, you might have.

YOUR RIGHTS UNDER ERISA

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

What are my ERISA rights?

ERISA provides that all Benefit Program participants are entitled to:

- examine, without charge, at the Employer's office, all Benefit Program documents, including insurance contracts and copies of all documents filed by the ERISA Plan Administrator with the U.S. Department of Labor or the Internal Revenue Service, such as detailed annual reports and Benefit Program descriptions;
- obtain copies of all Benefit Program documents and other Benefit Program information upon written request to the ERISA Plan Administrator, who may make a reasonable charge for copies of the materials; and
- continue health care coverage for yourself or dependents if there is a loss of coverage under the Benefit Program as a result of a qualifying event (see the topic "COBRA – EXTENDED COVERAGE"). You or your dependents may have to pay for such coverage.

Review this booklet and the documents governing the Benefit Program for the rules governing your COBRA continuation coverage rights.

How long does it take to receive copies?

The ERISA Plan Administrator is required to provide you copies of requested materials within 30 days. If you do not receive the material within this time frame, you may file suit in federal court. In such a case, the court may require the ERISA Plan Administrator to provide the requested materials and pay you up to $110 a day until you receive them, unless the delay was beyond the control of the ERISA Plan Administrator.

What if I believe my rights have been denied?

ERISA imposes duties upon the people or companies who are responsible for the operation of the Benefit Program. These people or companies are referred to as Fiduciaries. Fiduciaries must act solely in the interest of you and your dependents, as Benefit Program participants. As the ERISA Plan Sponsor your Employer is a Fiduciary and, as such, must not discharge you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Benefit Program or exercising your rights under ERISA.

What if I believe that I have been discriminated against?

You have the right to file suit in a federal court if you think your Employer or anyone else is discriminating against you or otherwise stopping you from exercising your rights under ERISA. If you win your lawsuit, the court may require the losing party to pay your legal costs and fees, in addition to whatever other penalties it may impose. However, if you lose, the court may order you to pay the costs and fees, (for example if it finds your claim was frivolous).

Is filing suit my only option?

No. If you have any questions or problems with the Benefit Program, you should first contact the ERISA Plan Administrator, who is also the agent for service of legal process. If the ERISA Plan Administrator does not

- Voluntarily taking poison, inhaling gas, or taking a drug or chemical not administered by a physician;
- War or any act of war, whether declared or not;
- Your commission of, or attempt to commit, a felony, or any loss sustained while incarcerated for the felony;
- Your participation in a riot;
- Your engaging in an illegal occupation;
- Release of nuclear energy;
- Your operating, riding in, or descending from any aircraft (including a hang glider), other than while a passenger on a licensed, commercial, non-military aircraft; and
- Bodily or mental infirmity, disease of any kind, or medical or surgical treatment for that infirmity or disease. This does not include bacterial infections resulting from an accidental cut or wound, or accidental ingestion of a poisonous food substance.

FILING A CLAIM

How do I (or how does my beneficiary) file a claim?

If a covered person dies as the result of an accident or illness, you or your beneficiary should apply for the insurance benefit as soon as possible. You or your beneficiary can obtain the appropriate forms and details about the claims procedure by calling RSL Specialty Products Customer Service at 1-866-375-0775, Monday through Friday, 8:30 a.m. to 5:30 p.m., ET.

When will I (or my beneficiary) know if the claim is denied?

If all or a part of the claim is denied, you or your beneficiary will be notified in writing within 90 days from the date the claim was received. Under some circumstances, the carrier can notify you or your beneficiary that it is extending this 90-day time frame by an additional 90 days. The denial notice will include: (a) the specific reason(s) for the denial; (b) the specific policy provision(s) on which the decision is based; (c) a description of any information needed to make the claim complete; (d) a statement of your or your beneficiary's right to review (on request and at no charge) relevant internal guidelines, documents and other information; and (e) an explanation of how to appeal for reconsideration of the decision.

How do I (or how does my beneficiary) appeal a denied claim?

If you or your beneficiary disagree with the decision, a review may be requested within 60 days of the initial denial. If the appeal is not submitted on time, you or your beneficiary generally will lose the right to appeal the denial. The appeal must be in writing, clearly stating the reason you or your beneficiary believes the denial is incorrect, and include any additional documentation that would support a further review of the claim. You or your beneficiary (on request and at no charge) may have reasonable access to and receive copies of all relevant documents concerning the claim. The claim will be reviewed and a decision will be issued within 60 days from the date the appeal was received. Under some circumstances, the carrier can notify you or your beneficiary that it is extending this 60-day time frame by an additional 60 days. If the decision on appeal continues to deny the claim, you or your beneficiary will be furnished with a notice of adverse benefit determination on review, setting forth: (a) the specific reason(s) for the denial; (b) the specific policy provision(s) on which the decision is based; (c) a statement of your or your beneficiary's right to review (on request and at no charge) relevant internal guidelines, documents and other information; and (d) a statement of your or your beneficiary's right to bring a lawsuit.

What if I (or my beneficiary) miss a deadline for filing a claim or appealing?

If you or your beneficiary do not submit a claim on time, do not appeal on time, or do not otherwise follow the claims procedures, you or your beneficiary may lose the right to file suit in court because of failure to exhaust the internal administrative appeals rights, which may be a prerequisite to bringing suit.

SHORT-TERM DISABILITY COVERAGE

What is the benefit for Short-Term Disability (STD)?

The STD Coverage pays up to 50% of your average weekly base pay received for work done for the ERISA Plan Sponsor (plus reported tips, but no overtime), subject to a maximum of $125 a week. For example, if you normally make $200 a week at your job, you will be paid $100 per week in STD payments. The STD Coverage pays for a maximum of 26 weeks. Your benefits under this coverage are reduced by 50% at age 70. In addition, while receiving benefits under this coverage, you do not have to pay the STD premiums. Enrollment in this coverage is only available to you, the employee. It is not available to your dependents.

When would I start receiving STD payments?

They begin after a 14-day elimination period; however, if you are hospitalized during that 14-day period, the STD Coverage begins paying immediately. To receive the benefits, you must become totally disabled due to a sickness while you are covered under the STD Coverage, or due to an injury from an accident that happens while you are covered under the STD Coverage. Total disability due to an injury must occur within 90 days of the accident.

What does "totally disabled" mean?

If you cannot do the duties generally and regularly required by your type of work due to injury or sickness, and your disability requires treatment by a licensed physician, you will be considered totally disabled. If you are no longer

850 - 854	INTRACRANIAL INJURY, EXCLUDING THOSE WITH SKULL FRACTURE
860 - 869	INTERNAL INJURY OF THORAX, ABDOMEN, AND PELVIS
870 – 897	OPEN WOUND
900 - 904	INJURY TO BLOOD VESSELS
910 - 919	SUPERFICIAL INJURY
920 - 924	CONTUSION WITH INTACT SKIN SURFACE (EXCLUDING 922.33)
925 - 929	CRUSHING INJURY
930 - 939	EFFECTS OF FOREIGN BODY ENTERING THROUGH ORIFICE
940 - 949	BURNS
950 - 957	INJURY TO NERVES AND SPINAL CORD
958 - 959	CERTAIN TRAUMATIC COMPLICATIONS AND UNSPECIFIED INJURIES
	Stroke (Cerebrovascular Accident - CVA)
430	SUBARACHNOID HEMORRHAGE
431	INTRACEREBRAL HEMORRHAGE
432	OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE
433	OCCLUSION AND STENOSIS OF PRECEREBRAL ARTERIES
434	OCCLUSION OF CEREBRAL ARTERIES
435	TRANSIENT CEREBRAL ISCHEMIA
436	ACUTE BUT ILL-DEFINED CEREBROVASCULAR DISEASE
437	OTHER AND ILL-DEFINED CEREBROVASCULAR DISEASE
438	LATE EFFECTS OF CEREBROVASCULAR DISEASE
	Childbirth
650	NORMAL DELIVERY
V27	OUTCOME OF DELIVERY

TERM LIFE COVERAGE

What is the life insurance benefit?

If you, the employee, die while you are covered by the life insurance benefit, your beneficiary will be paid $10,000. If your death is as the result of a covered accident, your beneficiary will be paid an additional $10,000. If any of your dependents older than 6 months, which you have enrolled in Dependent Term Life Coverage, die while covered, you will be paid $2,500. There is no matching accidental death benefit available for covered dependents. The benefit for dependents age 6 months or less is $500. Employee benefits under this coverage are reduced by 50% at age 70 and spouse benefits end when they reach age 70.

Who is the life insurance beneficiary?

Your life insurance benefits will be paid in equal shares to members of the first surviving class, as follows: spouse; children; parents; and then brothers and sisters. If no class has a survivor, the beneficiary is your estate. If you have selected coverage for your dependents, you are automatically the beneficiary for their life insurance benefits. If you are not living on the date of a covered dependent's death, the beneficiary is your estate.

CONVERSION OF YOUR TERM LIFE COVERAGE

What if I'm no longer employed, can I keep my Term Life Coverage?

Yes. If you had Term Life Coverage and now you are no longer employed or are not eligible, you have the right to convert your Term Life Coverage (not including the matching accidental death benefit) to an Individual Ordinary Life Policy. This must be done within 31 days of the end of your coverage.

How much will the conversion policy cost?

It will usually cost a lot more than what you previously paid for your Employer's Program. The cost will be based on your age and other factors.

What if I do want to convert my Term Life Coverage?

If you would like to apply for the conversion policy, you should contact the ERISA Plan Administrator for assistance with the application process.

EXCLUSIONS AND LIMITATIONS

The life insurance benefit is not payable for any loss of life during the first two years of coverage if death is caused by or results from suicide, while sane or insane.

The accidental death benefit is not payable for loss caused by or resulting from:

- Attempted suicide or intentionally self-inflicted injury, while sane or insane;

satisfactorily help you, contact the nearest area office of the Pension and Welfare Benefits Administration, United States Department of Labor. This federal agency is responsible for enforcing the law under ERISA and will be able to give you guidance as to what your rights are and how you can enforce them.

Where can I get more information on my rights under ERISA?

If you have any questions about this statement or about your rights under ERISA or COBRA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or: The Division of Technical Assistance and Inquiries Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You can also visit the Employee Benefits Security Administration's website at www.dol.gov/ebsa.

CONFORMITY WITH THE LAW

If any provision of the Benefit Program is contrary to any law to which it is subject, such provision is hereby amended to conform thereto. Nothing in the Benefit Program is intended to replace or affect any requirements for coverage by Workers' Compensation insurance.

BENEFIT PROGRAM TERMINATION, AMENDMENT, AND ADMINISTRATION

The Employer intends to continue the Benefit Program but reserves the right at any time, at its discretion, to terminate the Benefit Program, to modify the Benefit Program, to provide different cost-sharing between the Employer and participants, or to amend the Benefit Program in any respect. In the event the Benefit Program is terminated, any assets held in trust for the Benefit Program will be used to provide welfare benefits for employees of the ERISA Plan Sponsor or a successor, or they will be used in other ways not prohibited by the Internal Revenue Service regulations.

SUMMARY PLAN DESCRIPTION

This booklet, together with the copy you made of the form you used to enroll, is a Summary Plan Description. It provides a summary of the major provisions and benefits of the Benefit Program. It is also intended to tell you about the limitations and exclusions of the Benefit Program. Because this booklet is only a summary, it has not been written with all of the technical words and legal phrases used in the official Benefit Program documents. For full details about the insurance coverage, you may obtain a copy of the policy(ies) from the Employer. The official Benefit Program documents remain the final authority and, in the event of a conflict with this booklet, shall govern in all cases.

ASRM

ASRM is a Third Party Administrator that provides records keeping and claims paying services for the carrier identified under "BENEFIT PROGRAM INFORMATION". The carrier is the underwriter of the insurance contract(s). As a Third Party Administrator, ASRM has no discretionary powers under the Benefit Program and, in particular, has no discretionary power in the paying or denying of claims. ASRM is referred to as "RSL Specialty Products Administration" throughout this booklet.

PROGRAM FUNDING

Benefits will be provided on a fully-insured basis through the insurance contract(s) issued by the carrier directly to the ERISA Plan Sponsor. Participants are responsible for all required premiums, less any Employer contribution. The carrier provides certain policyholder and claims processing through ASRM (see above). The carrier serves as the claims review fiduciary with respect to the insurance contract(s) and the Benefit Program. The claims review fiduciary has the discretionary authority to interpret the Benefit Program and the insurance contract(s) and to determine eligibility for benefits. Decisions by the claims review fiduciary are complete, final and binding on all parties.

MEDICAL COVERAGE

INPATIENT BENEFITS

What are the hospital daily room & board benefits?

The Medical Coverage pays a hospital confinement daily benefit while a covered person is confined to a hospital as an inpatient. The amount of the daily benefit and maximum number of days vary based on the condition being treated.

Hospital confinement daily benefit amounts and per person maximums are:

Treatment of Mental & Nervous Conditions: $100 per day up to a maximum of 25 days per coverage year
Treatment of Alcohol & Substance Abuse: $100 per day up to a maximum of 25 days per coverage year
Treatment of All Other Covered Conditions: $400 per day up to a maximum of 90 days per coverage year

Are there any restrictions on the number of hospital days that can be covered for childbirth admissions?

The Medical Coverage does not restrict the covered person's doctor in authorizing the length of stay that is appropriate. The hospital confinement daily benefits payable under the Medical Coverage for childbirth are subject to the same limits and maximums that would apply with respect to a hospital stay for all other covered conditions.

Are inpatient surgeries covered?
Yes. The Medical Coverage pays $18 to $1,000 based on the specific surgical procedure performed for each inpatient surgery. See the Sample Inpatient Surgical Schedule later in this Medical Coverage section.

Is reconstructive surgery following a mastectomy covered?
Yes. A covered person who has a mastectomy is covered by the Medical Coverage for reconstructive breast surgery.

Does the Medical Coverage cover anesthesia administered during an inpatient surgery?
Yes. Each time a covered person has anesthesia administered during covered inpatient surgery, the Medical Coverage pays 20% of the benefit paid for the corresponding surgical procedure.

What is the hospital admission benefit?
The Medical Coverage pays a lump sum benefit when a covered person is admitted as an inpatient to the hospital for treatment of any of the covered conditions shown below. The benefit amount varies by condition and is payable based on the first diagnosis code listed on the claim form for the hospital admission. See the list of Covered Diagnosis Codes later in this Medical Coverage section.

When the first listed diagnosis code indicates the admission is for treatment of a covered condition, the applicable Hospital admission benefit amount and per person maximum are:

Cancer:	$4,000 per admission, maximum of 1 admission per coverage year.
Injury:	$2,000 per admission, maximum of 1 admission per coverage year.
Stroke:	$1,500 per admission, maximum of 1 admission per coverage year.
Childbirth:	$1,500 per admission, maximum of 1 admission per coverage year.
Heart Attack:	$3,000 per admission, or
Heart Disease:	$1,500 per admission. The hospital admission benefit is payable for either Heart Attack or Heart Disease, but not both, subject to a maximum of 1 admission per coverage year for both conditions.

Does the Medical Coverage cover inpatient services that are not specifically described in the benefits?
No. The Medical Coverage covers only inpatient hospital confinements and services that are described and categorized as inpatient surgical procedures and administration of anesthesia. Other services, such as inpatient doctors' visits and private-duty nursing, are not covered under the Medical Coverage and there is no benefit for these types of services.

OUTPATIENT BENEFITS

What are the benefits for outpatient doctors' visits?
The Medical Coverage pays for outpatient doctors' visits. The benefit amount and maximum number of visits vary based on the type of visit. Doctor visit benefit amounts and per person maximums are:

New patient office visit:	$75 per visit; maximum of 1 visit per coverage year
Established patient office visit:	$70 per visit; maximum of 3 visits per coverage year
Consultation office visit:	$100 per visit; maximum of 1 visit per coverage year
Emergency Room doctor visit:	$75 per visit; maximum of 1 visit per coverage year

What about wellness care?
The Medical Coverage pays for visits a covered person makes for the covered wellness care shown below. All wellness care performed at the same visit will be counted as one visit. Benefits will not be paid for more than 1 visit for wellness care per day for each covered person.

The benefit amount varies based on the type of wellness care. Wellness care benefit amounts and per person maximums are:

Annual Physical:	$75 per visit; maximum of 1 visit per coverage year
Mammogram Screening:	$50 per visit; maximum of 1 visit per coverage year
Prostate or Cervical Cancer Screening:	$35 per visit; maximum of 1 visit per coverage year

What are the outpatient radiology benefits?
The Medical Coverage pays for visits a covered person makes for outpatient diagnostic radiology services. All diagnostic radiology services performed at the same visit will be counted as one visit. Benefits will not be paid for more than 1 visit for diagnostic services per day for each covered person.

The benefit amount and maximum number of visits vary based on the type of diagnostic radiology service. Diagnostic radiology visit benefit amounts and per person maximums are:

Magnetic Resonance Imaging (MRI):	$150 per visit; maximum of 1 visit per coverage year
Computerized Tomography (CT) Scan:	$75 per visit; maximum of 1 visit per coverage year
All other radiology services:	$40 per visit; maximum of 5 visits per coverage year

Note: If these services are incurred as part of an emergency room visit, they are NOT covered under this benefit. See "What if I use an emergency room?" below.

203	MULTIPLE MYELOMA AND IMMUNOPROLIFERATIVE NEOPLASMS
204	LYMPHOID LEUKEMIA
205	MYELOID LEUKEMIA
206	MONOCYTIC LEUKEMIA
207	OTHER SPECIFIED LEUKEMIA
208	LEUKEMIA OF UNSPECIFIED CELL TYPE
230	CARCINOMA IN SITU OF DIGESTIVE ORGANS
231	CARCINOMA IN SITU OF RESPIRATORY SYSTEM
232	CARCINOMA IN SITU OF SKIN
233	CARCINOMA IN SITU OF BREASTAND GENITOURINARY SYSTEM
234	CARCINOMA IN SITU OFOTHER AND UNSPECIFIED SITES
235	NEOPLASM OF UNCERTAIN BEHAVIOR OF DIGESTIVE AND RESPIRATORY SYSTEMS
236	NEOPLASM OF UNCERTAIN BEHAVIOR OF GENITOURINARY ORGANS
237	NEOPLASM OF UNCERTAIN BEHAVIOR OF ENDOCRINE GLANDS AND NERVOUS SYSTEMS
238	NEOPLASM OF UNCERTAIN BEHAVIOR OF OTHER AND UNSPECIFIED SITES AND TISSUES
239	NEOPLASMS OF UNSPECIFIED NATURE
	Heart Attack (Myocardial Infarction) OR Heart Disease
410	ACUTE MYOCARDIAL INFARCTION
414.1	ANEURYSM OF HEART
414.11	ANEURYSM OF CORONARY VESSELS
414.12	DISSECTION OF CORONARY ARTERY
414.19	OTHER ANEURYSM OF HEART
390	RHEUMATIC FEVER WITHOUT MENTION HEART INVLV
391	RHEUMATIC FEVER W/HEART INVOLVEMENT
392	RHEUMATIC CHOREA
393	CHRONIC RHEUMATIC PERICARDITIS
394	DISEASES OF MITRAL VALVE
395	DISEASES OF AORTIC VALVE
396	DISEASES OF MITRAL&AORTIC VALVES
397	DISEASES OF OTHER ENDOCARDIAL STRUCTURES
398	OTHER RHEUMATIC HEART DISEASE
401	ESSENTIAL HYPERTENSION
402	HYPERTENSIVE HEART DISEASE
404	HYPERTENSIVE HEART&RENAL DISEASE
411	OTHER ACUTE & SUBACUTE FORMS ISCHEMIC HEART DISEASE
412	OLD MYOCARDIAL INFARCTION
413	ANGINA PECTORIS
414	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
415	ACUTE PULMONARY HEART DISEASE
416	CHRONIC PULMONARY HEART DISEASE
420	ACUTE PERICARDITIS
421	ACUTE AND SUBACUTE ENDOCARDITIS
422	ACUTE MYOCARDITIS
423	OTHER DISEASES OF PERICARDIUM
424	OTHER DISEASES OF ENDOCARDIUM
425	CARDIOMYOPATHY
426	CONDUCTION DISORDERS
427	CARDIAC DYSRHYTHMIAS
428	HEART FAILURE
429	ILL-DEFINED DESC&COMPLICATIONS HEART DISEASE
	Accidental Injury (does not include poisoning)
800 - 829	FRACTURES
830 - 839	DISLOCATIONS
840 - 848	SPRAINS AND STRAINS OF JOINTS AND ADJACENT MUSCLES

143	MALIGNANT NEOPLASM OF GUM
144	MALIGNANT NEOPLASM FLOOR OF MOUTH
145	MALIGNANT NEOPLASM OTHER & UNSPECIFIED PARTS OF MOUTH
146	MALIGNANT NEOPLASM OF OROPHARYNX
147	MALIGNANT NEOPLASM OF NASOPHARYNX
148	MALIGNANT NEOPLASM OF HYPOPHARYNX
149	MALIGNANT NEOPLASM OF OTHER AND ILL-DEFINED SITES WITHIN THE LIP, ORAL CAVITY, AND PHARYNX
150	MALIGNANT NEOPLASM OF ESOPHAGUS
151	MALIGNANT NEOPLASM OF STOMACH
152	MALIGNANT NEOPLASM OFSMALL INTESTINE, INCLUDING DUODENUM
153	MALIGNANT NEOPLASM OF COLON
154	MALIGNANT NEOPLASM OF RECTUM, RECTOSIGMOID JUNCTION & ANUS
155	MALIGNANT NEOPLASM OF LIVER & INTRAHEPATIC BILE DUCTS
156	MALIGNANT NEOPLASM OFGALLBLADDER & EXTRAHEPATIC BILE DUCTS
157	MALIGNANT NEOPLASM OF PANCREAS
158	MALIGNANT NEOPLASM OF RETROPERITONEUM & PERITONEUM
159	MALIGNANT NEOPLASM OF OTHER AND ILL-DEFINED SITES WITHIN THE DIGESTIVE ORGANS AND PERITONEUM
160	MALIGNANT NEOPLASM OF NASAL CAVITIES, MIDDLE EAR & ACCESSORY SINUSES
161	MALIGNANT NEOPLASM OF LARYNX
162	MALIGNANT NEOPLASM OF TRACHEA, BRONCHUS, & LUNG
163	MALIGNANT NEOPLASM OF PLEURA
164	MALIGNANT NEOPLASM OF THYMUS, HEART, & MEDIASTINUM
165	MALIGNANT NEOPLASM OF OTHER AND ILL-DEFINED SITES IN THE RESPIRATORY SYSTEM & INTRATHORACIC ORGANS
170	MALIGNANT NEOPLASM OF BONE AND ARTICULAR CARTILAGE
171	MALIGNANT NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE
172	MALIGNANT MELANOMA OF SKIN
173	OTHER MALIGNANT NEOPLASM OF SKIN
174	MALIGNANT NEOPLASM OF FEMALE BREAST
175	MALIGNANT NEOPLASM OF MALE BREAST
176	KAPOSI'S SARCOMA
179	MALIGNANT NEOPLASM OF UTERUS, PART UNSPECIFIED
180	MALIGNANT NEOPLASM OF CERVIX UTERI
181	MALIGNANT NEOPLASM OF PLACENTA
182	MALIGNANT NEOPLASM OF BODY OF UTERUS
183	MALIGNANT NEOPLASM OF OVARY AND OTHER UTERINE ADNEXA
184	MALIGNANT NEOPLASM OF OTHER AND UNSPECIFIED FEMALE GENITAL ORGANS
185	MALIGNANT NEOPLASM OF PROSTATE
186	MALIGNANT NEOPLASM OF TESTIS
187	MALIGNANT NEOPLASM OF PENIS AND OTHER MALE GENITAL ORGANS
188	MALIGNANT NEOPLASM OF BLADDER
189	MALIGNANT NEOPLASM OF KIDNEY AND OTHER AND UNSPECIFIED URINARY ORGANS
190	MALIGNANT NEOPLASM OF EYE
191	MALIGNANT NEOPLASM OF BRAIN
192	MALIGNANT NEOPLASM OF OTHER AND UNSPECIFIED PARTS OF NERVOUS SYSTEM
193	MALIGNANT NEOPLASM OF THYROID GLAND
194	MALIGNANT NEOPLASM OF OTHER ENDOCRINE GLANDS AND RELATED STRUCTURES
195	MALIGNANT NEOPLASM OF OTHER AND ILL-DEFINED SITES
196	SECONDARY AND UNSPECIFIED MALIGNANT NEOPLASM OF LYMPH NODES
197	SECONDARY MALIGNANT NEOPLASM OF RESPIRATORY AND DIGESTIVE SYSTEMS
198	SECONDARY MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES
199	MALIGNANT NEOPLASM WITHOUT SPECIFICATION OF SITE
200	LYMPHOSARCOMA AND RETICULOSARCOMA AND OTHER SPECIFIED MALIGNANT TUMORS OF LYMPHATIC TISSUE
201	HODGKIN'S DISEASE
202	OTHER MALIGNANT NEOPLASMS OF LYMPHOID AND HISTIOCYTIC TISSUE

Are outpatient pathology services covered?
Yes. The Medical Coverage pays $40 for each visit a covered person makes for outpatient diagnostic pathology services up to a per person maximum of 5 visits each coverage year. All pathology services performed at the same visit will be counted as one visit. Benefits will not be paid for more than 1 visit for pathology services per day for each covered person.
Note: If these services are incurred as part of an emergency room visit, they are NOT covered under this benefit. See "What if I use an emergency room?" below.

Are outpatient surgeries covered?
Yes. The Medical Coverage pays $32 to $1,000 based on the specific surgical procedure performed for each outpatient surgery. See the Sample Outpatient Surgical Schedule later in this Medical Coverage section.
Note: If your outpatient surgery is performed as part of an emergency room visit, it is NOT covered under this benefit. See "What if I use an emergency room?" below.

Does the Medical Coverage cover anesthesia administered during an outpatient surgery?
Yes. Each time a covered person has anesthesia administered during covered outpatient surgery, the Medical Coverage pays 20% of the benefit paid for the corresponding surgical procedure.
Note: If you receive anesthesia during an outpatient surgery performed as part of an emergency room visit, it is NOT covered under this benefit. See "What if I use an emergency room?" below.

What if I use an emergency room?
The Medical Coverage pays $500 for each visit to a hospital emergency room for up to a per person maximum of 2 visits each coverage year for the treatment of an injury; and $50 for each visit to a hospital emergency room for up to a per person maximum of 3 visits each coverage year for the treatment of a sickness. Benefits will not be paid for more than 1 emergency room visit per day for each covered person.

Does the Medical Coverage cover outpatient services that are not specifically described in the benefits?
No. The Medical Coverage covers only the types of services that are described and categorized as outpatient doctors' visits, outpatient wellness care, outpatient diagnostic radiology and pathology services, outpatient surgery and administration of anesthesia, emergency room visits, and outpatient prescription drug purchases. Other services, such as injections and durable medical equipment, are not covered under the Medical Coverage and there is no benefit for these types of services.

PRESCRIPTION DRUG BENEFITS

Is there a benefit for outpatient prescription drug expenses?
Yes. For each generic drug prescription you have filled, the Medical Coverage pays the lesser of the cost of the prescription or $25. Benefits for generic drugs are subject to a per person maximum of 18 prescriptions each coverage year.

Can I use any pharmacy?
Yes, but you can use the Prescription Drug ID Card you will receive with the Medical Coverage to help save money and stretch your benefit dollars at a pharmacy that participates in the Express Scripts, Inc. network.

How does the Prescription Drug ID Card work?
Most pharmacies participate in the Express Scripts, Inc. network, but you should check with the pharmacy before you make your purchase or call Express Scripts, Inc. at 1-866-282-1491 for providers in your area. Participating pharmacies provide discounts of up to 15% on all prescriptions when you present your card. You will not have to file a claim on purchases made at participating pharmacies. The pharmacist will tell you exactly what to pay.

What happens if I have to purchase a prescription before I receive my Prescription Drug ID Card?
Your outpatient prescription drug benefits begin the same day as your other Medical Coverage benefits. However, you cannot take advantage of the network features of the prescription benefits until you receive your Prescription Drug ID Card. And, it may take a few weeks for you to receive your card. If you need to purchase a prescription before you get your card, you will have to: 1) check with the pharmacy before you make your purchase to see if it participates in the Express Scripts, Inc. network; and 2) pay the full, undiscounted price for your prescription. Once you receive your Prescription Drug ID Card, you can: 1) call Express Scripts, Inc. at 1-866-282-1491 for a claim form; and 2) file a claim for benefits under the Benefit Program with Express Scripts, Inc. Do not file your prescription drug claims with RSL Specialty Products Administration.

What if I use a non-participating pharmacy?
You must pay the full price up front. Then you must call Express Scripts, Inc. at 1-866-282-1491 and request a claim form. File the claim with Express Scripts, Inc. You will be reimbursed up to the applicable benefit amount, subject to the coverage year maximum (for in- or out-of-network purchases). Do not file your prescription drug claims with RSL Specialty Products Administration.

Are there other ways that I can lower the cost of my prescriptions?
If you take a generic medication on a regular basis, a mail order service is available that may provide an even

larger discount. You may visit Express Scripts, Inc. at their website www.express-scripts.com or call Express Scripts, Inc. at 1-866-282-1491 for more information.

What if I have a prescription from my dentist?
You may only purchase medical prescriptions, except when the prescription is issued in connection with covered dental treatment for an accident covered under your Medical Coverage.

COMMONLY USED TERMS

What is the "coverage year"?
It is the period of time during which benefit maximums accumulate. Each new coverage year, the maximums are reset. You will find the coverage year under "BENEFIT PROGRAM INFORMATION". The coverage year should not be confused with the ERISA Plan Fiscal Year End.

What are "covered services"?
The Medical Coverage usually covers services that are for the treatment of injury and sickness. These services must be medically necessary, incurred while the Medical Coverage is still in force, and not excluded.

What is a "hospital"?
A hospital is an institution operated by law for the care and treatment of injured or sick persons that has organized facilities for diagnosis and surgery (or has a contract with another hospital for these services), and has 24-hour nursing service. A hospital is not an institution that is primarily a rest, nursing or convalescent home, a home for the aged, an alcoholism or drug addiction treatment facility, or a facility for treatment of mental disorders.

What does "injury" mean?
Injury is a covered person's bodily injury caused by an accident that results, directly and independently of all other causes, in a covered loss. All injuries sustained in one accident, including all related conditions and recurring symptoms of the injuries, will be considered one injury.

What are "inpatient" services?
Inpatient services are incurred at licensed hospital facilities when you are admitted as an inpatient and charged for at least one day's room & board.

What are "outpatient" services?
Outpatient services are incurred at doctors' offices, free-standing clinics, and hospitals when you are not admitted as an inpatient.

What does "sickness" mean?
Sickness is a covered person's sickness or disease that results, directly and independently of all other causes, in a covered loss.

EXCLUSIONS AND LIMITATIONS
No benefits will be paid for loss caused by or resulting from:
- Outpatient treatment of mental or nervous conditions;
- Outpatient treatment of alcoholism or substance abuse;
- Intentionally self-inflicted injuries, suicide, or any attempt thereat while sane or insane;
- Acts of declared or undeclared war;
- The covered person's commission of a felony;
- Work-related injury or sickness;
- Eye examinations for glasses, any kind of eye glasses, or prescriptions therefore;
- Hearing examinations, or hearing aids;
- Dental care or treatment other than care of sound, natural teeth and gums required on account of injury resulting from an accident that happens while covered under the Medical Coverage, and rendered within 6 months of the accident;
- Reading or interpreting the results of any diagnostic pathology or radiology tests;
- Cosmetic surgery, except covered services rendered in connection with cosmetic surgery needed for breast reconstruction following a mastectomy or an accident that happens while covered under the Medical Coverage. The surgery needed for an accident must be performed within 90 days of the accident;
- Brand name drugs and drugs not requiring a prescription; and
- Services provided by a member of the covered person's immediate family or services provided by the ERISA Plan Sponsor.

FILING A CLAIM

How do I file a claim?
Your medical provider will most likely want to file a claim for you using his or her own form. If you need to file a claim yourself, you may request a claim form from your Employer, or you may call RSL Specialty Products Customer Service at 1-866-375-0775. Claims should be mailed to: RSL Specialty Products Administration, Claims

31575	Diagnostic Laryngoscopy	$261
	Digestive System	
42820	Tonsillectomy and Adenoidectomy	$657
43235	Upper Gastrointestinal Endoscopy	$712
43239	Upper Gastrointestinal Endoscopy with Biopsy	$784
45330	Diagnostic Sigmoidoscopy	$234
45378	Diagnostic Colonoscopy	$1,000
45380	Colonoscopy and Biopsy	$1,000
45384	Colonoscopy with Removal of Tumor(s), Polyp(s)	$1,000
46600	Diagnostic Anoscopy	$109
47562	Laparoscopic Cholecystectomy	$1,000
49505	Repair Initial Inguinal Hernia, age 5 or over	$1,000
	Urinary System	
50590	Lithotripsy	$1,000
51741	Complex Uroflometry	$253
52000	Cystoscopy	$446
53670	Catheterization	$182
	Male/Female Genital System	
54150	Circumcision	$642
55250	Vasectomy	$1,000
55700	Biopsy of the Prostate	$508
57452	Colposcopy	$222
57454	Colposcopy with Biopsy	$262
57511	Cryocautery of the Cervix	$370
58100	Endometrial Sampling	$253
58120	Dilation and Curettage	$609
58558	Hysteroscopy with Biopsy	$703
58662	Laparoscopy with Excision of Lesions	$1,000
	Nervous System	
64450	Injection, Anesthetic Agent, Peripheral Nerve or Branch	$251
64721	Carpal Tunnel Surgery	$918
	Eye and Ocular Adnexa System	
65222	Remove Foreign Body from the Eye	$142
66984	Removal of Cataracts, Stage One Procedure	$1,000
68761	Close Tear Duct Opening	$361
69210	Removal of Impacted Ear Wax	$99
69436	Create Eardrum Opening	$332

COVERED DIAGNOSIS CODES
The hospital admission benefit varies based on the first ICD-9 diagnosis code listed on the claim form for the hospital admission. All ICD-9 diagnosis codes for which a benefit is payable are shown below. (All subcodes within a major code are included unless otherwise noted.)

Covered Diagnosis Codes

ICD-9 Code	Description
	Cancer (Malignant Neoplasm)
140	MALIGNANT NEOPLASM OF LIP
141	MALIGNANT NEOPLASM OF TONGUE
142	MALIGNANT NEOPLASM OF MAJOR SALIVARY GLANDS

	Urinary System	
51840	Attach Bladder/Urethra	$1,000
52332	Cystoscopy	$326
	Male/Female Genital System	
54150	Circumcision	$308
55845	Extensive Prostate Surgery	$1,000
57260	Repair of Vagina	$1,000
58150	Total Hysterectomy	$1,000
58260	Vaginal Hysterectomy	$1,000
58262	Vaginal Hysterectomy with Removal of Tube(s) and/or Ovary(s)	$1,000
58550	Laparoscopy, Surgical with Vaginal Hysterectomy	$1,000
58605	Ligation or Transection of Fallopian Tube	$692
58611	Ligation or Transection of Fallopian Tube at Cesarean Delivery	$170
58720	Removal of Ovary/Tube(s)	$1,000
	Maternity Care and Delivery	
59120	Surgical Treatment of an Ectopic Pregnancy	$1,000
59400	Routine Obstetric Care including Vaginal Delivery and Antepartum & Postpartum Care	$1,000
59510	Routine Obstetric Care including Cesarean Delivery and Antepartum & Postpartum Care	$1,000
	Nervous System	
63030	Low Back Disk Surgery	$1,000
63047	Lumbar Laminectomy	$1,000
63048	Lumbar Laminectomy, each Additional Segment	$447
63075	Neck Spine Disk Surgery	$1,000

Sample Outpatient Surgical Schedule
$1,000 Maximum Benefit

CPT Code	Description	Benefit Amount
	Integumentary System	
10021	Fine Needle Aspiration without Imaging	$191
10040	Acne Surgery	$178
10060	Incision and Drainage of Abscess	$221
10120	Incision and Removal of Foreign Body	$227
11200	Removal of Skin Tags	$161
11400	Removal of Skin Lesion	$212
11730	Removal of Nail Plate	$164
12001	Repair Superficial Wound(s)	$317
17000	Destroy Benign or Premalignant Lesions	$138
17003	Destroy Benign or Premalignant Lesions 2-14	$32
	Musculoskeletal System	
20550	Injection; Tendon Sheath, Ligament, Ganglion Cyst	$142
20610	Arthrocentesis, Aspiration of Major Joint or Bursa	$146
25600	Closed Treatment of Distal Radial Fracture	$600
29075	Application of a Forearm Cast	$154
29125	Application of a Forearm Splint	$122
29405	Application of a Short Leg Cast	$161
29877	Knee Arthroscopy	$1,000
	Respiratory System	
30520	Repair of Nasal Septum	$963
31231	Nasal Endoscopy, Diagnostic	$255

Department, 505 S. Lenola Road, Suite 231, Moorestown, NJ 08057. Claims must be submitted within one year of the date of the loss. The carrier reserves the right to require a medical examination at its expense. For Claims Customer Service call 1-866-375-0775, Monday through Friday, 8:30 a.m. to 5:30 p.m., ET.

When will I know if my claim is denied?

If all or a part of your claim is denied, you will be notified in writing within 30 days from the date your claim was received. Under some circumstances, the carrier can notify you that it is extending this 30-day time frame by an additional 15 days. The denial notice will include: (a) the specific reason(s) for the denial; (b) the specific policy provision(s) on which the decision is based; (c) a description of any information needed to make the claim complete; (d) a statement of your right to review (on request and at no charge) relevant internal guidelines, documents, and other information; and (e) an explanation of how to appeal for reconsideration of the decision, including your right to bring a lawsuit. If you are required to submit additional information to support your claim, you will have 45 days to do so.

How do I appeal a denied claim?

If you disagree with the decision, you may request a review within 180 days of the initial denial. If you do not submit your appeal on time, you generally will lose the right to appeal the denial. Your appeal must be in writing, clearly stating the reason you believe the denial is incorrect, and include any additional documentation that you feel would support a further review of your claim. You (on request and at no charge) may have reasonable access to and receive copies of all relevant documents concerning your claim. The reviewer of your appeal will be a different person or persons from the reviewer of your initial claim and will not be a subordinate of the initial reviewer. Your claim will be reviewed and a decision will be issued within 60 days from the date your appeal was received. If the decision on appeal continues to deny your claim, you will be furnished with a notice of adverse benefit determination on review, setting forth: (a) the specific reason(s) for the denial; (b) the specific policy provision(s) on which the decision is based; (c) a statement of your right to review (on request and at no charge) relevant internal guidelines, documents, and other information; and (d) a statement of your right to bring a lawsuit.

What if I miss a deadline for filing a claim or appealing?

If you do not submit your claim on time, do not appeal on time, or do not otherwise follow the claims procedures, you may lose your right to file suit in court because you may have failed to exhaust your internal administrative appeals rights, which may be a prerequisite to bringing suit.

Is there any coordination of benefits?

This Medical Coverage does not coordinate benefits with any other coverage that you might have. That means we will not reduce your benefit because you have other coverage that pays you for the same expenses. If you have coverage from another source, that other coverage could reduce their benefits based on what this Medical Coverage pays you. An example would be Medicare or Medicaid. The rules of these programs require that your benefits under those plans be reduced by the amount of benefits you would receive under this Medical Coverage.

IMPORTANT NOTE: Your Medical Coverage allows access to important medical provider and pharmacy provider networks that utilize negotiated charges which may save you money. You may contact Beech Street (at 1-866-907-3619) or Express Scripts (at 1-866-282-1491) to find network providers in your area.

NON-INSURANCE BENEFITS

Your Medical Coverage allows access to important non-insurance benefits as described below. The suppliers of these plans are not affiliated with the Carrier, which is not responsible for the content of the plans and cannot be held liable for any services provided or not provided by these suppliers.

What does membership in the VSP Access Plan give me?

Membership in the VSP Access Plan is a separate benefit that you receive when you are enrolled in the Medical Coverage. This benefit, which is provided through Vision Service Plan, offers discounts on eye exams and prescription glasses from VSP network doctors. When you visit a network doctor, you can receive a 20% discount on your eye exam, a 15% discount on your contact lens exam, a 20% discount on your frame, lenses and lens options when a complete pair of prescription glasses is purchased. You also can receive discounts on laser vision correction. The discounts for prescription glasses and contact lenses are only available from the VSP network doctor who provided your eye exam within the past 12 months. For questions regarding the VSP Access Plan, call VSP at 1-800-877-7195 or visit their website at www.vsp.com.

What does membership in the 24-Hour Nurse Helpline Plan give me?

Membership in the 24-Hour Nurse Helpline Plan is a separate benefit that you receive when you are enrolled in the Medical Coverage. This benefit offers a telephone service that allows you to ask questions and receive information about your health, illnesses and medications. You have unlimited access to registered nurses via a toll-free number 24 hours a day, 365 days a year. These nurses are specially trained to offer prompt, confidential medical counseling to help you make informed decisions about your health and the medical care you receive. However, the nurses do not diagnose or provide treatment.

The benefits include:

- Toll-free, confidential availability to registered nurses 24 hours a day at 1-800-982-2401.
- Information and guidance for dealing with common symptoms.
- Explanations on what to expect during a medical test.
- Help from a registered nurse who can answer questions regarding:
  - diagnostic and surgical procedures
  - a recently diagnosed medical condition
  - prescription and over the counter medication information

What does membership in the Online Wellness Improvement Plan give me?

Membership in the Online Wellness Improvement Plan is a separate benefit that you receive when you are enrolled in the Medical Coverage. This benefit offers an online service that allows you access to daily wellness articles and health tips, personalized workout programs for all ages and fitness levels, guidance on nutrition, weight loss and exercise, access to health risk assessments and calculators, and disease prevention studies. You must have access to the Internet to take advantage of this benefit.

To use this benefit:

- You must first enroll in My E Wellness; visit www.myewellness.com and click on the "New Member" button.
- You must provide your first and last name and enter your membership ID number (found on your medical ID card) as both your User ID and Password, then click "Continue".
- You will be prompted to provide your e-mail address and to change your User ID & Password to something you can easily remember. Then click "Continue" and you will be taken to the MyEWellness.com Member Home Page.

If you have any questions regarding the Online Wellness Improvement Plan, please call the My E Wellness Customer Service Department at 1-800-308-0374.

What does membership in the On Call Travel Assistance Plan give me?

Membership in the On Call Travel Assistance Plan is a separate benefit that you receive when you are enrolled in the Medical Coverage. This benefit offers a 24-hour, toll-free service that provides a comprehensive range of information, referral, coordination and arrangement services designed to respond to most medical care situations and many other emergencies you may encounter when you travel. This benefit also provides pre-trip assistance, including passport/visa requirements, foreign currency and weather information. All services under this benefit are provided by On Call International (On Call).

When traveling more than 100 miles from home or in a foreign country, the following services are offered:

Pre-Trip Assistance
- Inoculation requirements information
- Passport/visa requirements
- Currency exchange rates
- Consulate/embassy referral
- Health hazard advisory
- Weather information

Emergency Personal Services
- Urgent message relay
- Interpretation/translation services
- Emergency travel arrangements
- Recovery of lost or stolen luggage/personal possessions
- Legal assistance and/or bail

Emergency Medical Transportation*
- Emergency evacuation
- Medically necessary repatriation
- Visit by family member or friend
- Return of traveling companion
- Return of dependent children
- Return of vehicle
- Return of mortal remains

Medical Services Include:
- Medical referrals for local physicians/dentists
- Medical case monitoring
- Prescription assistance and eyeglass replacement
- Convalescence arrangements

*Emergency Medical Transportation services are subject to a maximum combined single limit of $250,000. Return of vehicle is subject to $2,500 maximum limit.

To use this benefit at any time before or during a trip, you may contact On Call for emergency assistance services. In the U.S., call toll-free at 1-800-456-3893. Worldwide, call collect at 1-603-328-1966

What does membership in the Vitamins & Nutritional Supplements Plan give me?

Membership in the Vitamins & Nutritional Supplements Plan is a separate benefit that you receive when you are enrolled in the Medical Coverage. This benefit offers discounted prices on natural vitamins, nutritional supplements, bath, personal care products, and even healthy pet products.

To use this benefit, visit www.HealthFitLabs.com and enter MEMBER as the coupon code at checkout to receive an additional 15% off your order. The online prices are already reduced 5-35%. You can also save up to 30% off catalog prices. Call 1-888-757-2454 to request a catalog or place an order. Mention MEMBER as your coupon code.

SAMPLE SURGICAL SCHEDULES

Below are sample outpatient and inpatient surgical schedules. The schedules list many common surgeries and their corresponding benefit amounts. The benefit amounts are based on the relative value assigned to the particular surgical procedure in the 2002 National Physician Fee Schedule Relative Value File published by the Centers for Medicare and Medicaid Services (CMS).

The Medical Coverage will also cover a surgical procedure that is not listed in the sample schedules, as long as the procedure is classified as a surgery in the CMS. The benefit amount for a surgical procedure that is not listed in the sample schedules will be consistent with the other benefit amounts shown in the sample schedules.

Sample Inpatient Surgical Schedule
$1,000 Maximum Benefit

CPT Code	Description	Benefit Amount
	Integumentary System	
17000	Destroy Benign or Premalignant Lesion	$73
17003	Destroy Benign or Premalignant Lesions 2-14	$18
19240	Modified Radical Mastectomy	$1,000
	Musculoskeletal System	
20937	Spinal Bone Autograft	$381
22554	Neck Spine Fusion	$1,000
22585	Additional Spinal Fusion	$756
22612	Lumbar Spine Fusion	$1,000
22845	Insert Spine Fixation Device	$1,000
27130	Total Hip Arthroplasty	$1,000
27447	Total Knee Arthroplasty	$1,000
	Respiratory System	
31500	Insert Emergency Airway	$254
31622	Diagnostic Bronchoscopy	$330
32020	Insertion of Chest Tube	$466
	Cardiovascular System	
33518	Coronary Artery Bypass, Two Venous Grafts	$566
33519	Coronary Artery Bypass, Three Venous Grafts	$831
33533	Coronary Artery Bypass, Single Arterial Graft	$1,000
33534	Coronary Artery Bypass, Two Arterial Grafts	$1,000
35301	Rechanneling of Artery	$1,000
36216	Catheter Placement in Artery	$593
36489	Insertion of Catheter in Vein	$293
36533	Insertion of Implantable Venous Access Device	$745
	Digestive System	
43235	Upper Gastrointestinal Endoscopy	$300
43239	Upper Gastrointestinal Endoscopy, Biopsy	$342
43280	Laparoscopy, Fundoplasty	$1,000
44140	Partial Removal of the Colon	$1,000
44950	Appendectomy	$1,000
44970	Laparoscopy, Appendectomy	$1,000
45378	Diagnostic Colonoscopy	$454
45380	Colonoscopy and Biopsy	$536
47562	Laparoscopic Cholecystectomy	$1,000
47563	Cholecystectomy with Cholangiography	$1,000
49000	Exploratory Laparotomy	$1,000
49568	Hernia Repair with Mesh	$572