Community Health Systems

Group Health Plan

Summary Plan Description

Amended and Restated as of
January 1, 2009

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Introduction

This document serves as the written plan document and the summary plan description ("SPD") of the Community Health Systems Group Health Plan (the "Plan"). The Plan provides Eligible Employees and their eligible Dependents with a wide range of healthcare benefits including medical, dental and vision care benefits.

The Plan encourages cost-effective use of medical services and includes provisions to help ensure that Eligible Employees and eligible Dependents receive Medically Necessary care, provided or ordered by recognized Network and Out-of-Network Providers, following generally accepted medical practices, and in the most appropriate setting.

Using Community Health Systems Hospitals and Network Providers will generally provide the greatest Plan benefit for medical services. The Plan has contracted with Physicians and Other Providers (sometimes referred to as "Participating Providers" or "Network Providers") to provide discounted medical services that may not be available at the Employee's worksite.

This Plan may be administered in whole or in part by third-party service providers and may be funded in whole or in part through insurance arrangements. Community Health Systems may enter into certain contracts with such service providers and insurers. In the event that the benefits provided under this Plan exceed or differ from those set forth in the contracts with such service providers or insurers, Community Health Systems reserves the right to limit the terms of and benefits provided under this Plan so as not to exceed or differ from the benefits provided for under the contracts with the service providers or insurers. Furthermore, to the extent this Plan conflicts with the terms of any applicable collective bargaining agreement, the terms provided under such collective bargaining agreement shall govern with respect to the applicable bargaining unit.

Community Health Systems presently intends to continue the Plan for the benefits of its Eligible Employees and their eligible Dependents, but it reserves the right, acting through any duly authorized officer, to terminate, amend, or suspend the operation of the Plan at any time with or without notice. However, any such action that affects the continuation of this Plan will not adversely affect any claims incurred before the action was taken or made effective.

The Plan consists of this Plan document together with the appendices, which are incorporated into this document and made a part hereof. A separate HIPAA Privacy Notice is being provided to you with this Plan document.

Eligibility and Enrollment

Who is Eligible for this Plan?

You are an Eligible Employee if you are an Employee of a Community Health Systems ("CHS") Affiliated Employer and you meet all of the following conditions:

- You satisfy the Eligibility Waiting Period listed on Appendix E.
- You meet the Active Work Requirement, are on an approved leave for the period set forth in Appendix E, or are on temporary layoff (provided you are reinstated within the period set forth in Appendix E); or you are participating in a nursing scholarship program approved by your employer under which you are regularly scheduled to work a specified number of hours or specified work schedule per week as agreed to by your employer.
- You are regularly scheduled to work the number of hours per period listed on Appendix E. Employees who are classified as "PRN, " "per diem," or "temporary" are not Eligible Employees regardless of the number of hours that they are scheduled to work.
- You participate in the Community Health Systems Flexible Benefits Plan or other cafeteria plan sponsored by a CHS Affiliated Employer (unless the Affiliated Employer maintains a separate group health plan).

However, you are not eligible to participate in the Plan with respect to any particular type of coverage (medical, dental, and/or vision) if you participate in another group health plan sponsored by your Employer that provides the same type of coverage.

The day on which you first become an Eligible Employee is the day on which all of the above requirements have been satisfied.

Which of my Dependents is Eligible?

Dependents that are eligible include:

- Your Spouse.
- Your unmarried Children under age 19 who have the same principal abode as you and who do not provide over one-half of their own support.
- Your unmarried Children under age 25 if they are full-time students, as determined by the written guidelines of the accredited institution in which the Child is enrolled, and they are primarily dependent on you for their support.
- Your unmarried Children under age 20 who are pursuing a high school diploma through a home school program that meets any requirements of the state in which they reside, who are primarily dependent on you for their support, and whose yearly gross income is less than the federal dependent tax exemption amount for the year in which coverage is provided. The Plan may from time to time request statements from the participant certifying that all the requirements of this provision are, and continue to be, met. The Plan Administrator is not required to accept the certification of the participant as conclusive evidence of eligibility under this provision.
- If you are a Covered Person, your unmarried Children under age 26 if they are participating in a religious mission on a full-time basis, and you provide over one-half of their support.
- Your physically or mentally disabled Children, regardless of their age, if they are unmarried and unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment as certified by a Physician that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve months, and either (a) they have the same principal abode as you, or (b) you provide over one-half of their support and they are not the qualifying children of any other person. The physical or mental disability must have begun before your Child reached the Dependent Child Limiting Age (19 or 25 as noted above). The Plan may from time to time request proof

satisfactory to the Plan Administrator of the continuation of the disability and the need for your financial support. The Plan Administrator is not required to accept the certification of the Physician or any other third party as conclusive evidence of the determination of a disability.

- If both husband and wife are Employees, their Children will be covered as Dependents of the husband or wife but not of both as determined by the Plan Administrator. In addition, if both husband and wife are Employees, neither can be covered as both an Employee and a Dependent. If a Covered Person changes status from Employee to Dependent or Dependent to Employee and the Covered Person is covered continuously under this Plan before, during, and after the change in status, amounts paid by the Covered Person towards any Deductible will be credited to the Covered Person; the same out-of-pocket, lifetime, Substance Abuse, transplant, or other Plan maximums would in such case continue to apply to the Covered Person regardless of the change in status including the Maximum Lifetime Benefit.

Is there a Waiting Period under the Plan?

The Eligibility Waiting Period begins on the first day you begin work with CHS or other Affiliated Employer. You will not be considered an Eligible Employee until you have satisfied this Eligibility Waiting Period. Additionally, your Dependents, if any, will not be considered to be eligible Dependants unless you have satisfied the Eligibility Waiting Period. Coverage will be effective as of the first day of the month following satisfaction of the Eligibility Waiting Period. However, there is no Eligibility Waiting Period for Eligible Employees who participate in an approved medical residency program that requires immediate participation in the Plan; in such case, coverage will be effective on the date of hire by CHS or other Affiliated Employer.

How and when do I enroll in the Plan?

You must enroll yourself and your eligible Dependents by using the CHS Benefits website at www.chsbenefits.net, within 30 days of first becoming eligible. If you do not apply for coverage for yourself or your eligible Dependents within 30 days of first becoming eligible, you and your eligible Dependents will be considered HIPAA Late Enrollees. As HIPAA Late Enrollees, you will be required to wait until the next annual enrollment to enroll in the Plan unless you or your eligible Dependents experience a Change of Status Event as described below.

Under HIPAA, the Plan will permit an Eligible Employee or eligible Dependent to enroll as a HIPAA Special Enrollee if the Eligible Employee or eligible Dependent was covered under a group health plan or had health insurance at the time coverage was previously offered. Such coverage must have been COBRA coverage that was exhausted or coverage by other health plans that ended due to loss of eligibility or employer contributions toward the coverage were terminated.

Also, effective as of April 1, 2009, you and your eligible Dependents may enroll in the Plan if the following conditions are met: (1) You or your eligible Dependent is covered under a Medicaid plan (under title XIX of the Social Security Act) or under a State child health plan (under title XXI of the Social Security Act) and your coverage or your eligible Dependent's coverage under such plan is terminated as a result of loss of eligibility for such coverage and you request coverage under the Plan not later than 60 days after the date of termination of such coverage; or (2) You or your dependent becomes eligible for assistance, with respect to coverage under the Plan through a Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if you request coverage under the Plan not later than 60 days after the date you or your eligible Dependent is determined to be eligible for such assistance.

When can I change coverage for myself or my Dependents?

You will be given the opportunity to change your coverage elections annually. If you do not elect coverage for yourself or for your Dependents when first eligible, you must wait until the Plan's next

annual enrollment to enroll in the Plan unless you experience a Change of Status Event, as described below.

A Change of Status Event is generally any one or more of the following events (or as otherwise provided under the CHS Flexible Benefits Plan or required by law):

- Birth, adoption, or placement for adoption.
- Other changes in number of Dependents (*e.g.,* death of Dependent).
- Marriage.
- Other changes in marital status (*e.g.*, death of Spouse, divorce, legal separation, annulment).
- Change in employment status of Employee, Spouse, or Dependent (*e.g.,* full-time to part-time or part-time to full-time).
- Dependent satisfies or ceases to satisfy eligibility requirements (*e.g.*, attainment of age, change in student status).
- Change in place of residence of Employee, Spouse, or Dependent.
- Judgment, decree, or order (*e.g.,* a Qualified Medical Child Support Order).
- Entitlement to Medicare or Medicaid.
- Significant cost or coverage changes.
- FMLA leave.
- Loss or termination of other coverage as a HIPAA Late Enrollee.

Generally, if you experience a Change of Status Event during the Plan Year, you may make a change to your elections provided that the change is *consistent with* the Change of Status Event, and the request to change your elections is made within 30 days of the Change of Status Event. Proof of the change may be required (i.e., marriage certificate, divorce decree, or other documents required by the Plan Administrator). However, if you are already enrolled, or have been enrolled during the Plan Year, in the Plan, you may only change number of Covered Persons (e.g., Employee, Employee and Spouse, Employee and Child(ren), or Family) covered under the Plan. You may not change the coverage option (e.g., from the standard medical to the basic medical) if you experience a Change of Status Event during the Plan Year. If you are not already enrolled in the Plan (or a particular benefit under the Plan, such as medical, dental, and/or vision coverage) and you experience a Change of Status Event, you may enroll in any of the benefit options for which you are eligible.

Except in the case of birth or adoption, your coverage will become effective the first day of the month after the completed enrollment application or form is received. In the case of birth or adoption, coverage for your Dependent child will become effective as of the date of birth, adoption, or placement for adoption. If you get married or acquire a new Dependent as a result of birth, placement for adoption, or adoption, you, your Spouse, and Dependents may be enrolled as HIPAA Special Enrollees.

If you fail to request a change in your elections within the 30-day period, you will generally have to wait until the next annual enrollment or a later Change of Status Event to change your coverage.

SUMMARY OF PERMITTED CHANGES IN COVERAGE

Change of Status Event	**When request must be made**	**When the change is effective**
Birth (*HIPAA Special Enrollee*).	Within 30 days of birth.	As of the date of birth.

Adoption or placement for adoption (*HIPAA Special Enrollee).*	Within 30 days of adoption or placement.	As of the date of adoption or placement.
Other changes in number of Dependents.*	Within 30 days of change.	1st day of the month following request.
Marriage (*HIPAA Special Enrollee).*	Within 30 days of marriage.	1st day of the month following request.
Other changes in marital status.*	Within 30 days of change.	1st day of the month following request.
Change in employment status.*	Within 30 days of change.	1st day of the month following request.
Disqualification/requalification of eligibility of a Dependent.*	Within 30 days of disqualification/requalification.	1st day of the month following request.
Change in residence.*	Within 30 days of change.	1st day of the month following request.
Judgments, decrees, or orders.	As set forth in the judgment, decree, or order.	As set forth in the judgment, decree, or order.
Entitlement to Medicare or Medicaid.	Within 30 days of entitlement.	1st day of the month following request.
FMLA leave.	At time of request for leave.	During FMLA period.
HIPAA Late Enrollees.	Within 30 days of loss or termination of coverage.	1st day of the month following request.
**Medicaid or SCHIP Special Enrollees.	Within 60 days of loss of eligibility for coverage or becoming eligible for assistance through a Medicaid plan or State child health plan.	1st day of the month following request.

*These change of status events must be *on account of* and *consistent with* a change in status that affects eligibility for coverage under the Plan.
**Effective April 1, 2009.

Can I continue my coverage if I am not working?

Coverage under the Plan may continue for you and your Dependents for up to the leave period set forth in Appendix E in the event of:

- Approved FMLA Leave.
- Approved leave due to Illness or Injury under a workers' compensation program.
- Approved Summer Leave Program.
- Approved vacation, sick leave, jury duty, or other approved leaves of absence.
- Other leave required to be provided by law.

If different types of leave occur consecutively, all leaves will be added together for purposes of determining the period.

Your contributions will remain the same as for an Active Employee during this leave. After the permitted leave period, if you are eligible, you may elect continuation coverage under COBRA. If you elect to continue your coverage during FMLA, you must make your required contributions on a timely basis. No more than 30 days grace period will be permitted. If you do not continue your coverage during FMLA, you and your Dependents will be reinstated without evidence of good health on the date you return to work from the leave so long as you return on the earlier of the first working day following the day your FMLA leave ends or on the 91st day following the date your FMLA leave began.

What happens when I return to work after an approved leave?

When you return from an approved leave, unless you experience a Change of Status Event, an annual enrollment period occurs while you are on leave, or otherwise lose coverage under the Plan, your coverage elections under the Plan will automatically be reinstated at the same benefit level as was in effect prior to your leave. If an annual enrollment period occurs during your leave, you may elect any coverage options during the annual enrollment period for which you are eligible. If you experience a Change of Status Event while you are on leave, you may change your medical, dental, and/or vision coverage elections as outlined in the section titled "When can I change coverage for myself or my Dependents."

What happens if I become eligible for Medicare?

If you or your Spouse becomes eligible for Medicare while you are an Active Employee, you may continue to be covered primarily by the Plan with secondary coverage paid by Medicare as provided by law. This provision will apply to a Covered Person eligible for Medicare whether or not he or she has actually enrolled in Medicare.

What is the cost of coverage?

CHS pays most of the cost of the health benefits that you elect for yourself and your Dependents. You pay your portion of the cost through pre-tax payroll deductions in accordance with the provisions of the Community Health Systems Flexible Benefits Plan or other cafeteria plan adopted by your employer. Your Human Resources Department can provide you with the current costs of available coverage.

When does my coverage end?

Your coverage under this Plan will end:

- On the last day of the month in which your employment terminates or in which you become ineligible to participate in the Plan.
- On the date payments required towards the cost of coverage under of the Plan are not made by you (except as permitted during FMLA absences).
- On the date the Plan terminates for any reason.

Your Dependent's coverage under this Plan will end:

- When your coverage under this Plan terminates, as discussed above.
- On the last day of the month in which your Dependent ceases to be an eligible Dependent.

Whether hospitalized or otherwise provided Covered Services, benefits end on the date your coverage ends.

If two Employees (husband and wife) are Covered Persons under the Plan and the Employee who is covering the Dependent Children terminates coverage, coverage of the Dependent may be continued by the other Covered Person with no waiting period so long as coverage has been continuous.

Are there any special provisions regarding employees who transfer between CHS Affiliated Employers or become employed by a CHS Affiliated Employer through a merger or acquisition?

If you become a Covered Person under the Plan as a result of a transfer from an Affiliated Employer that maintains a separate group health plan or as a result of a merger or acquisition of your Employer, the Plan Administrator may waive or otherwise adjust all or part of the Deductibles, Out-of-Pocket Maximums, or Maximum Lifetime Benefit under the Plan. Any determination regarding such waiver or adjustment will be made in the sole discretion of the Plan Administrator.

Can I reinstate my coverage if I am rehired?

For Employees generally: If you are terminated or laid-off and are rehired within 90 days of the last day worked, you and your Dependents will be eligible for coverage on the first of the month following the date of your rehire without satisfaction of any Eligibility Waiting Period, provided the Employee applies for reinstatement within 30 days of his or her rehire date. Employees who are rehired more than 90 days after their employment ends will be treated as a new Employee and the Eligibility Waiting Period will apply.

For Employees of Watsonville Community Hospital: If you voluntarily resign or are involuntarily terminated and are rehired, you must satisfy another 90-day waiting period. Employees who are laid off and rehired within 6 months after employment ends will be reinstated as of the first day of the month following their rehire date without satisfaction of any Eligibility Waiting Period, provider the Employee applies for reinstatement within 30-days of his or her rehire date.

What is a Certificate of Creditable Coverage? Will I receive one?

A Certificate of Creditable Coverage generally verifies the beginning and ending date of coverage as well as who was covered and type of coverage elected. You will be provided with a Certificate of Creditable Coverage, free of charge, when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for HIPAA Late Enrollees) after your enrollment date in other coverage you obtain. Requests for Certificates of Creditable Coverage should be made to the Plan Administrator at the address provided under Administration Information. The Plan Administrator will provide a Certificate of Creditable Coverage in response to a request made by, or on behalf of, you at any time while you are covered under the Plan and up to 24 months after coverage ceases. After the request is received, the Plan will provide the Certificate of Creditable Coverage by the earliest date that the Plan, acting in a reasonable and prompt fashion, can provide it.

COBRA Coverage

What is COBRA and how does it apply to me?

COBRA continuation coverage is a temporary extension of coverage under the Plan. The following generally explains COBRA continuation coverage, when it may become available to you and your Family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by Federal law. COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your Family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under Federal law, you should contact the Plan Administrator.

COBRA continuation coverage is a continuation of Plan coverage that would otherwise end because of a life event known as a Qualifying Event. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your Dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

A Qualifying Event is a loss of coverage as a result of:

- Your death while an Employee.
- The termination of your employment (except for gross misconduct) or the reduction of hours of your employment.
- Your divorce or legal separation from your Spouse.
- Your becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare).
- Your Dependent Child ceasing to be a Dependent Child under the Plan.
- A bankruptcy proceeding commencing with respect to the employer from whose employment you retired at any time.

When does COBRA begin and end?

Provided you timely elect COBRA continuation coverage, eligibility begins the day after the date your coverage ended because of the Qualifying Event and will end on the earlier of:

- The date the maximum continuation period expires.
- The date the qualified individual obtains other group health plan coverage and satisfies pre-existing condition limitations, if any, that apply.
- The date the qualified individual becomes entitled to benefits under Medicare.
- The date payment of the required cost is not made when due (subject to the 30-day grace period).
- The date on which the Employer ceases to provide any group health plan to any Employees.
- For extended coverage for disability for a Covered Person who becomes disabled for Social Security purposes during the first 60 days of continuation coverage, the month that begins after 30 days following the date of the final determination under title II or XVI of the Social Security Act that the qualified individual is no longer disabled.

- COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA continuation coverage lasts for up to a total of 36 months. When the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if an Eligible Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). Otherwise, when the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:
    - First, if you or anyone in your Family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire Family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.
    - Second, if your Family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent Children in your Family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available to the Spouse and any Dependent Children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

What are the continuation rights under USERRA?

The Plan is administered in accordance with the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Under USERRA, if you leave your job to perform military service, you have the right to elect to continue your coverage under the Plan for you and your dependents for up to 24 months while in the military.

Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in the Plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries. Contact the TPA if you have any questions about your rights under USERRA.

Are there any special notice rules that apply to COBRA?

Yes. You have the responsibility to inform the Plan Administrator of a divorce, legal separation or a Child losing Dependent status under the Plan within the applicable time limits described below. If you or your eligible Dependents become disabled for Social Security purposes within the first 60 days of COBRA coverage, you must notify the Plan Administrator as described below after the date of

determination and after receiving any final determination that you are no longer disabled. Finally, in the case of a Qualifying Event that is a second Qualifying Event, it is the responsibility of the qualified beneficiary to notify the Plan Administrator if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, all within applicable time limits.

If you are required to provide notice to the Plan of a Qualifying Event or disability determination, you must provide notice to the Plan Administrator on a form provided by the Plan Administrator or in a written form that is otherwise acceptable to the Plan Administrator within the applicable time limit described in this SPD. Such notice may also be provided to the Plan Administrator by your authorized representative. Such notice must include information describing the Qualifying Event or disability determination, including the name of the Plan, the Covered Person and other qualified beneficiaries, if any, the Qualifying Event or disability determination, and the date of such Qualifying Event or disability determination. In addition, notice of a Qualifying Event or disability must include the following supporting documentation, or such other proof as may be reasonably required by the Plan Administrator, and be provided as noted below:

(1) In the event of a Qualifying Event that is a divorce or legal separation of an Employee from his or her Spouse, a final decree of divorce or order issued by a court of competent jurisdiction or such other proof as may be reasonably required by the Plan Administrator of legal separation. You must notify the Plan Administrator within 60 days after the later of the date of divorce or separation or the date of loss of coverage.

(2) In the event of a Qualifying Event that is a Child losing Dependent status, a birth certificate, a notice of disenrollment from school, evidence of new residency, or such other proof as may be reasonably required by the Plan Administrator that the Child is no longer the Dependent of the Eligible Employee. You must notify the Plan Administrator within 60 days after the later of the date that the child lost dependent status or the date of loss of coverage.

(3) In the event of a Qualifying Event that is a second Qualifying Event after a qualified beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months, a birth certificate, a notice of disenrollment from school, evidence of new residency, a death certificate, final divorce decree or order, a notice of Medicare entitlement, or such other proof as applicable as may be reasonably required by the Plan Administrator that such qualified beneficiary is a Child losing Dependent status or the Spouse or Dependent Child of a former Employee who has elected COBRA continuation coverage and who has died, divorced or separated from the qualified beneficiary, or become entitled to Medicare benefits (under Part A, Part B, or both). You must notify the Plan Administrator within 60 days after the later of the date of the second qualifying event or the date of loss of coverage.

(4) In the event of disability determination or loss of disabled status, a written copy of the determination by the Social Security Administration that the qualified beneficiary has been determined to be disabled under Title II or XVI of the Social Security Act at any time during the first 60 days of continuation coverage or that the qualified beneficiary has been subsequently determined not to be disabled must be provided to the Plan Administrator. In the case of notification to the Plan Administrator of an initial disability determination, you must notify the Plan Administrator of the disability determination by the date of loss of continuation coverage. In the case of notification to the Plan Administrator that you are no longer disabled, you must notify the Plan Administrator of such determination by the end of the 30th day after such determination by the Social Security Administration.

The Plan may not deem notice to have been provided untimely if such notice, although not containing all of the information required by the Plan, is provided within the applicable time limit and the Plan Administrator is able to determine from such notice the name of the Plan, the Covered Person and qualified beneficiaries, the Qualifying Event, and the date on which the Qualifying Event occurred. However, the Plan Administrator may require a notice that does not contain all of the information required by the Plan to be supplemented with the additional information necessary to meet the Plan's reasonable notice requirements for such notice in order for the notice to be deemed to have been provided in accordance with the requirements of the Plan.

After the Plan is notified of a Qualifying Event, the Plan Administrator will notify you that you have the option to elect COBRA and will send you an application for coverage. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Eligible Employees may elect COBRA continuation coverage on behalf of their Spouses, and you may elect COBRA continuation coverage on behalf of your Dependent Children. You have 60 days within which to elect COBRA coverage. The 60-day period begins to run from the later of (i) the date you would lose coverage under the Plan, or (ii) the date of the Plan notice of the option to elect COBRA coverage. An election will be considered made on the date you return the application to the Plan.

In order to protect your Family's rights, you should keep the Plan Administrator informed of any changes in the addresses of Family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Can COBRA benefits change?

Yes, as and when benefits under the group health plan change. By law COBRA benefits are required to be the same as those made available to similarly situated Active Employees. If the Employer changes the group coverage, COBRA coverage will also change.

What is the cost of COBRA?

The Plan Administrator will notify you of the cost of coverage at the time you experience a Qualifying Event. Generally, COBRA cost is 102% of the applicable premium (150% of the applicable premium during the disability extension). The maximum COBRA costs are limited by law but are established by the Plan and subject to change including certain permitted changes during the plan year. COBRA costs will generally change for each new plan year. The Plan reserves the right to increase premiums to correct any mistake and to collect any shortfall resulting from a mistake.

However, if you are an "assistance eligible individual" under the American Recovery and Reinvestment Act of 2009, you will be treated as having paid the full COBRA cost if you pay 35% of the full COBRA cost during the assistance period. Generally, the assistance period will end on the earliest of:

- 9 months after the date on which you first received the premium assistance;
- the end of the maximum COBRA coverage period under the group health plan; or
- the date on which you become eligible under any other group health plan (other than a plan providing only dental, vision, counseling, or referral services, a health care flexible spending arrangement, or an on-site medical facility) or Medicare.

Summary of COBRA Timeframes

Timeframe to elect COBRA Coverage (General)	**60 days from the later of (i) the date you would lose coverage under the Plan, or (ii) the date of the Plan notice that you have the option to elect COBRA coverage.** An election will be considered made on the date you return the application to the Plan.

Timeframe to remit first COBRA premium	**Your first COBRA premium must be made no later than 45 days after you elect COBRA coverage.** That payment must include all premiums owed from the date on which COBRA coverage began. This means that your first premium could be larger than the monthly premium that you will be required to pay going forward. There is a grace period of 30 days for all premium payments after the first payment.
Maximum period of COBRA Continuation Coverage	► 18 months, where the loss of coverage is due to a reduction in hours or termination of employment of the Eligible Employee (other than by reason of gross misconduct). ► 29 months, where the Covered Person is determined under Title II or XVI of the Social Security Act to be "disabled" during the first 60 days of continuation coverage, in which case the 18-month period above is extended to 29 months, provided the Covered Person has given notice of the determination to the Plan on a date that is both within 60 days after the date the determination is issued and before the end of the 18-month period. ► 36 months: if a Qualifying Event (other than a bankruptcy proceeding) occurs during the 18 months after a loss of coverage due to the termination or reduction of hours of the employee, the COBRA period is extended to 36 months.

Note: This section is not intended to provide and will not be construed to provide any rights greater than those provided under COBRA or other applicable laws.

What happens if I incur claims during my COBRA election period?

Your coverage will be treated as terminated as of the date of your Qualifying Event. Prior to the time you elect COBRA and make your COBRA premium payment, your claims will not be paid. However, once you timely elect COBRA and make your premium payment, your coverage will be reinstated retroactively to the date of the Qualifying Event and the claims you incurred during this period will be paid.

Are there any special appeal rights regarding COBRA?

Yes. Notwithstanding any other rights under the Plan, if you are denied treatment as an "assistance eligible individual" (as defined under the American Recovery and Reinvestment Act of 2009), you may appeal the denial directly to the U.S. Department of Labor.

If you have questions.

For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Medical Care Benefits

What are the Plan benefits?

Medical Care benefits are provided to a Covered Person for Covered Services that are Medically Necessary for the treatment of an Illness or Injury while covered under the Plan. Well Child care and other preventive care benefits are also included under the Plan. All Covered Charges for Covered Services are subject to the Maximum Plan Benefit limits shown in the Schedule of Benefits (see appendices) and must not exceed the Usual and Customary Charges.

- Benefits are not payable for any services not listed as Covered Services or that are subject to exclusions under the Plan.
- Benefits will be provided for Inpatient services only if the Covered Person is admitted.
- Benefits will be provided only for Covered Services prescribed or performed by a Physician or Other Professional Provider.
- Benefits for Covered Services will be provided only for services and/or supplies that are normally included in the charges for services rendered by Provider(s).
- Preauthorization of benefits provided in one instance will not obligate the Plan to provide preauthorization of such benefits in any other instance.
- Benefits are limited as provided for in this Plan including the appendices to this Plan.

What is the basis for payment of eligible Medical Care benefits?

Covered Charges under the Plan for Medical Care are based on one or more of the following:

- Usual and Customary Charges or Maximum Allowable Charges, whichever is applicable.
- Negotiated fee schedule.
- Negotiated per diem rates.
- Diagnostic related groups ("DRGs").

What is the Plan's Out-of-Pocket Maximum?

The Plan's Out-of-Pocket Maximum is shown in the Schedule of Benefits for your coverage. After the aggregate of any other payments under this Plan reach the Out-Of-Pocket Maximum shown in the Schedule of Benefits for the coverage elected, the Plan pays 100% of your Covered Charges for the balance of the Plan Year, excluding applicable Copayments and charges by Out-of-Network Hospitals or Out-of-Network Providers that are over the maximum allowable amounts.

Certain benefit amounts may not apply to the Out-of-Pocket Maximum:

- Penalties for failure to obtain Precertification for Inpatient stays.
- Penalties for failure to obtain a required Second Surgical Opinion, if required by the Plan Administrator.
- Your Schedule of Benefits contains a description of charges excluded from your Plan's Out-of-Pocket Maximum and situations subject to benefit reductions.

What is the Maximum Lifetime Benefit?

The Maximum Lifetime Benefit, as shown in the Schedule of Benefits, is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by or for a Covered Person. If the Schedule of Benefits provides for an Out-of-Network Maximum Lifetime Benefit, the Out-of-Network Maximum Lifetime Benefit further limits the amount of the Maximum Lifetime Benefit that is available for charges incurred by or for a Covered Person for Out-of-Network Provider and Out-of-Network Hospital charges. Such Out-of-Network Maximum Lifetime Benefit does not increase the total amount of benefits available under the Plan. However, for the purposes of determining the Maximum Lifetime Benefit, the total

amount of benefits paid under any other group health plan maintained by CHS or any Affiliated Employer will be applied to reduce and offset the Maximum Lifetime Benefit available under the Plan.

What about pre-existing conditions?

The Plan does not exclude Covered Charges for pre-existing conditions.

Is Case Management Required?

The Plan will identify Covered Persons with potentially complicated medical needs, chronic illness and/or catastrophic illnesses or injuries that may be suited for alternative treatment plans. After evaluation of the Covered Person's condition, the Plan may, at its sole discretion, determine that alternative treatment is Medically Necessary and Appropriate.

The Plan requires case management for all organ transplants. If your Provider tells you that you need a transplant, you or your Provider should contact the third party administrator that administers your claims immediately for referral to a transplant case manager. Additional procedures other than transplants may also require case management. The claims administrator will contact the Covered Person in the event case management is necessary for other procedures. Failure to notify the claims administrator of proposed transplant services, or to coordinate all required case management services with the Plan's case manager will result in the reduction or exclusion of payment for those services.

Does the Plan require use of CHS Hospitals?

The Plan encourages use of CHS Hospitals whenever possible. Depending on the type of service, if a CHS Hospital where you live or work can provide the treatment or service and you do not utilize the CHS Hospital, either no Hospital benefits will be paid or you will receive a lower benefit payment.

Does the Plan include other Network Providers?

At many locations, CHS has contracted with Network Providers to provide services that are not available at CHS Hospitals. Consult the Medical Schedule of Benefits for the Plan's Network and Out-of-Network benefits and limitations (Appendix A). Your Human Resources Department can assist you with locating Network Providers in your area.

Will the Plan pay Out-of-Network Benefits?

Depending on your location and the availability of Network Providers, your Plan design may provide for reduced benefits or no benefits if an Out-of-Network Provider is utilized. Consult your Medical Schedule of Benefits (Appendix A) for provisions relating to Out-of-Network services.

Is Precertification required?

The Plan requires Precertification for certain Covered Services. You, your Physician or the Hospital must call for Precertification (check the back of your Plan ID Card or ask your Human Resources Department for the phone number) before the confinement begins or the service is provided. Services for which Precertification is required include, but are not limited to, the following:

- Inpatient Hospital stays;
- Skilled nursing facility and rehabilitation facility admissions;
- Certain Outpatient Surgeries and procedures;

- Specialty Drugs;
- Certain prescription drugs;
- Advanced Radiological Imaging services;
- Home Health Care; and
- Any other Covered Services as may be determined from time to time by the Plan Administrator.

The Plan's utilization review representative reviews services to determine whether they are:

- Medically Necessary;
- Efficiently provided in the most appropriate setting; and
- Consistent with patterns of care found in an established managed care environment for treatment of a particular Illness, Injury or medical condition.

The Precertification process also includes, but is not limited to:

- Admission review to determine whether an Inpatient admission or an admission not subject to admission review was Medically Necessary.
- Length of stay assignment to indicate the number of Inpatient days usually Medically Necessary to treat the Covered Person's medical condition.
- Continued stay review to determine whether a continued Inpatient stay is Medically Necessary.
- Discharge planning to assess the Covered Person's need for additional treatment after discharge from a Hospital.

In the event of an Emergency Admission to any Hospital, you, your Physician or the Hospital must notify the utilization review organization indicated on the back of your Plan ID Card of an Emergency Admission within 24 hours or the next working day if your admission is on a weekend.

Precertification does not guarantee eligibility, indicate that a hospitalization or service is a Covered Charge, or guarantee *any* Plan benefit in advance. It is intended only to confirm the appropriate level of care based on information submitted from the attending Physician or Other Professional Provider regarding the patient's condition at the time of the hospitalization or service.

No benefits will be paid if a Covered Person fails to comply with these Precertification provisions.

What services are covered?

The Plan's Covered Services are subject to the Maximum Plan Benefit limits shown in the Medical Schedule of Benefits (Appendix A). A charge is incurred on the date that the service or supply is performed or furnished.

Hospital Services	**Inpatient Services.** Services and supplies received in and billed by a Hospital. ► Room, board, and general nursing care in a: - semi-private room, or - private room (if the Hospital has semi-private rooms, then benefits will be paid only up to the Hospital's most common semi-private room rate), or - room in a special care unit as approved by the Plan Administrator ► Use of operating, delivery and treatment rooms ► Drugs and medicines, including take-home drugs ► Blood and blood plasma, if not donated or replaced ► Sterile dressings, casts, splints and crutches ► Anesthetics and their administration ► Diagnostic Services ► Therapy Services Benefits will not be provided for room and board charges incurred on the date of discharge unless both admission and discharge occur on the same day. **Outpatient Services**. The following will be considered Covered Services when rendered by a Hospital on an Outpatient basis: ► Treatment of accidental Injury ► Treatment of an Illness that occurs suddenly and requires immediate medical attention ► Removal of sutures, anesthetics and their administration, and other surgical services provided by a Hospital employee other than the surgeon or assisting surgeon ► Drugs, crutches, and medical supplies **Pre-Admission Testing**. Certain tests and studies are commonly required before a scheduled Hospital admission. Such tests and schedules will be considered Covered Services when received in a Hospital prior to the date of your admission as an Inpatient (and billed by such Hospital).

	Emergency Services. Prior Authorization for Emergency Services is not required. However, once the Covered Person's medical condition has been stabilized, Precertification will be required for continuing Inpatient care or transfer to another facility. Benefits will be denied if such Prior Authorization is not obtained.
Surgery	Surgical procedures are considered Covered Services when performed by a Physician or Other Professional Provider. Benefits will also be available for Surgery needed to restore an impaired bodily function if the condition occurs while a person is covered under this Plan and results from: ► Disease ► Birth defect ► Surgery (excluding non-functional scar revision) ► Accidental Injury **Outpatient Surgery**. Benefits will be provided as stated in the Medical Schedule of Benefits (Appendix A). **Multiple or Bilateral Surgical Procedures**. When two or more covered surgical procedures are performed at the same time or in one surgical setting,

	benefits will be based on: ► the amount of benefits for the procedure for which the highest dollar amount would be billed (if charges for the surgical procedures are different), and ► up to one-half of the benefits which are available with respect to the other covered surgical procedure(s) whether performed through the same or separate incisions. **Assistant Surgeon**. Benefits will be provided for Surgery performed by a Physician who actively assists the operating surgeon in the performance of a covered surgical procedure provided: ► no intern, resident, or other staff Physician is available; and ► such procedure is recognized by Plan Administrator as requiring an assistant surgeon. Benefits will be limited to no more than 20% of the fee for Covered Services rendered by the primary surgeon. **Anesthesia Services**. Benefits will be provided for the administration of anesthetics used in connection with a covered surgical procedure and ordered by the attending Physician. The anesthesia must be administered by a Provider other than the operating or assisting surgeon. **Second Surgical Opinion Consultation**. Benefits will be provided for a second surgical opinion and related diagnostic tests obtained within three months of the first opinion. If the second surgical opinion conflicts with the first opinion, benefits will be provided for a third opinion and related diagnostic tests. Second and third surgical opinions must be given by a Physician who is not in the same medical group or practice (a) as the Physician who initially recommended the Surgery or (b) the Physician who rendered either the second or third surgical opinion.

Medical Services	**Inpatient Medical Services**. When you are confined in a Hospital, the attending Physician's charges for Surgery, professional care and visits by Other Professional Provider are covered. Except for staff consultations required by Hospital rules, benefits will be provided for consultation services when requested by the attending Physician. **Outpatient Medical Services**. Benefits may be provided for the following services when rendered by a Physician or Other Professional Provider: ► Treatment of accidental Injury ► Treatment of an Illness that occurs suddenly and requires immediate medical attention ► Home and office visits for the examination, diagnosis, and treatment of an Illness or Injury
Diagnostic Services	Benefits will be available for the following when determined by a Physician to be Medically Necessary: ► X-ray and other radiology services ► Laboratory and pathology services ► Cardiographic, encephalographic, and radioisotope tests ► Allergy testing ► Mammography screening, provided such examinations are conducted with equipment designed and used primarily for such examinations ► Prostate specific Antigen (PSA) test ► Group B streptococcus testing on pregnant or newborn Covered Persons as recommended by the American College of Obstetricians and Gynecologists and the Center for Disease Control
Therapy Services	The following forms of therapy are covered: ► cardiac rehabilitation ► home infusion therapy ► occupational therapy ► physical therapy ► respiratory therapy ► speech therapy
Maternity Services	The Plan covers Pregnancy and childbirth on the same basis as an Illness. Only eligible charges for Complications of Pregnancy are payable for the Pregnancy of a Dependent Child.
Ambulance	Benefits are available for an appropriate land or air transportation for Covered Persons: ► from their home or the scene of an accident or medical Emergency to the nearest Hospital where appropriate medical or surgical services are available ► between Hospitals with prior approval unless an emergency situation exists

Outpatient Nursing and Skilled Nursing Visits	Benefits are available for certain nursing services and skilled nurse visits when Medically Necessary and rendered by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), provided: ► professional skills of an R.N. (as compared with other nursing skill levels) are Medically Necessary to provide the appropriate level of care, and ► such services are ordered by a Physician Inpatient private duty nursing services in an acute care Hospital are excluded. Pre-Treatment Certification of nursing services must be obtained in accordance with the following procedures: ► Request for Certification must be submitted along with a plan of treatment before services are rendered. ► If approved by the Plan, the Covered Person and nurse (or nursing agency) will be given notice of such approval, specifying the number of days and hours per day ("certified days") for which benefits will be available. ► Benefits may be provided for additional nursing services if such services are precertified. A request for recertification must be submitted in the same manner as the initial request for Pre-Treatment Certification. However, the request for certification of additional days of, approval will be in writing and specify an additional number nursing services should be accompanied by nurses' notes for the initial certified days, as well as a new plan of treatment. If such request is approved of days and hours per day of coverage.
Skilled Nursing Facility	Skilled Nursing Facility Benefits for Inpatient care in a Skilled Nursing Facility are provided on the same basis as benefits for other Inpatient Hospital services subject to Plan maximums.
Dental Services	Medical care benefits are available under this Plan only for dental work needed as the result of an accidental Injury to the jaw, natural teeth, mouth, or face. To be covered, the accident must occur on or after the date the injured Covered Person's coverage begins. An Injury due to chewing or biting or received in the course of other dental procedures will not be considered an accidental Injury.
Anesthesia For Dental Services	Medical care benefits will be available for anesthesia, as well as Inpatient or Outpatient Hospital expenses, in connection with a dental procedure if such procedure involves: ► Complex oral surgical procedures which have a high probability of complications due to the nature of the Surgery. ► Concomitant systemic disease for which the patient is under current medical management and which increases the probability of complications. ► Mental Illness or behavioral condition which precludes dental Surgery in an office setting. ► Use of general anesthesia when your medical condition requires such procedure be performed in a Hospital. ► Dental Surgery performed on a Covered Person eight years of age or younger, where such procedure cannot safely be provided in a dental office setting.

Prescription Drugs	Benefits are available for Prescription Drugs for use by Covered Persons outside of a Hospital. In order to be considered covered, such drug must be: ► prescribed in writing by a licensed Physician on or after coverage begins; ► approved for use by the Food and Drug Administration (FDA) for the prescribed indication (however, benefits will be available for a drug which is prescribed to treat a recognized indication which has not been approved by the FDA for such indication, provided such drug is (a) otherwise approved by the FDA and, (b) approved by the Plan Administrator based on peer-reviewed medical literature or standard reference compendia); ► dispensed by a licensed Pharmacist; and ► not be available for purchase without a prescription. Over-the-counter drugs (not requiring a prescription), prescription devices, vitamins not by law requiring a prescription, lifestyle drugs, cosmetic drugs, and/or Prescription Drugs dispensed in a Physician's office are excluded except as otherwise covered in the Plan. However, benefits will be available for: ► contraceptive medications and devices ► drugs or formula required to treat Pheny-l ketornuria ► injectable insulin, oral hypoglycemic agents, and syringes Certain Prescription Drugs may require Prior Authorization or may be subject to certain quantity level limits and other limitations (including but not limited to exclusion from coverage if such Prescription Drugs have an over-the-counter equivalent), as determined by the Plan Administrator.
Durable Medical Equipment	Benefits are provided for the rental or, if deemed by the Plan Administrator as appropriate, the purchase of Durable Medical Equipment when Medically Necessary and prescribed in writing by a Physician. Benefits are also available to fit, adjust, repair, or replace Durable Medical Equipment, provided the need for this arises from normal wear or physical development-and not as a result of improved technology or loss, theft, or damage. When the equipment is rented and the rental extends beyond the original prescription, a Physician must re-certify that the equipment is Medically Necessary for continued treatment. If a re-certification is not submitted, benefits will cease on the date through which benefits were previously prescribed.
Prosthetic Appliances	Benefits are provided for prosthetic appliances if needed to replace all or part of an absent or malfunctioning body part, including surrounding tissue. Benefits are also available to fit, adjust, repair, or replace an appliance, provided the need for this arises from normal wear or physical development and not as a result of improved technology or loss, theft, or damage to the appliance or device.
Organ and Tissue Transplant Donor Surgery	Subject to other terms and conditions of the Plan, certain human organ and tissue transplants from a living donor, as approved by the Plan Administrator, will be covered. ► When the transplant recipient and donor are Covered Persons, benefits will be provided for surgical removal and implant of a donated organ or tissue (depending on whether Covered Person is donor or recipient). ► If only the recipient is a Covered Person, both the donor and recipient are entitled to benefits (benefits provided on behalf of the donor will be charged against the Covered Person's Maximum Lifetime Benefit).

	If only the donor is a Covered Person, benefits will be available only for the donor (limited to those not available from any other source, including other insurance programs, or any government program(s)).
Bone Marrow Transplant	Benefits are provided for bone marrow transplants which are Medically Necessary and Appropriate for the condition under the Plan.
Home Health Care	Subject to the other terms and conditions of the Plan, benefits will be provided in the amount specified in the Schedule of Benefits for the following services when Covered Services prescribed by the attending Physician and rendered by and billed by a Home Health Care Agency: ► Part-time or intermittent nursing care by a visiting R.N., L.V.N., L.P.N.. (not to include private duty nursing) ► Physical therapy and respiratory therapy by persons licensed to perform such services ► Oxygen and its administration ► Diagnostic Services The Plan requires that all Home Health care be precertified. No Home Health Care benefits will be provided for: ► Transportation services ► Services rendered primarily for Custodial Care ► Dietitian services ► Social case work or homemaker services ► Maintenance therapy ► Food, including home-delivered meals
Home Infusion Therapy	Benefits are available for Home Infusion Therapy including supervision and management by a Physician of such services when Medically Necessary and approved by the Plan Administrator. Benefits for Physician management and supervision of Home Infusion Therapy will be on a per diem basis. A request for certification must be submitted to the plan administrator in order to be approved. If approved, the patient and the Provider will be given notice of such approval, specifying the number of days for which benefits will be available. Benefits may be provided longer for Home Infusion Therapy if such services are precertified. A request for re-certification must be submitted in the same manner as the initial request for pre-treatment certification. However, the request for certification should be accompanied by documentation of the need for additional days of such services. If benefits are approved, approval will be in writing and specify an additional number of days of benefits available.
Hospice Home Care Benefits	Benefits will be provided under this paragraph for specific types of services related to the care of a terminally ill patient (where life expectancy is six months or less). Benefits will be paid as stated in the Schedule of Benefits, provided the diagnosis of terminal Illness is certified by your primary or attending Physician. The following will be considered Covered Services when provided by a Hospice: ► Skilled nursing by an R.N., L.P.N., L.V.N., or a nurse's aide working under the supervision of an R.N. ► Medical social services by a Social Worker that is certified by the state in which the Hospice is operating and employed by the Hospice agency and under the direction of a Physician ► Reasonable expense for medication prescribed for the control or palliation

	of a terminal illness, necessary medical equipment, and supplies ► Services of a Home Health Aide furnished by the Hospice and supervised by an R.N. ► Services of a Home Health Aide to provide personal care necessary for the maintenance of safe and sanitary conditions in areas of the house used by the patient ► Physical therapy and respiratory therapy provided for the purposes of symptom control or to enable the patient to maintain activities of living at home and basic functional skills ► Bereavement counseling, consisting of services provided to the patient's immediate family after the patient's death, limited to two visits provided within three months after the patient's death The following will not be considered Covered Services when provided by a Hospice: ► Housekeeping services, delivered or prepared meals, and convenience and comfort items not related to the palliation or management of a terminal illness ► Supportive environmental items such as air conditioners, air fresheners, ramps, handrails, or intercom systems ► Transportation, chemotherapy, radiation therapy, enteral and parenteral feeding, private duty nursing, home hemodialysis, or medical research ► Visits made to the home by a Physician ► Inpatient care at any facility, including a Hospice, Hospital, Skilled Nursing Facility, intermediate care facility, or any other institution ► Psychiatric Care ► Services provided by volunteer agencies or pastoral counseling services ► Items, services, or supplies not specified as Covered Services
Diabetes Treatment	Benefits are available for treatment, medical equipment, supplies and Outpatient self-management training and education, including nutritional counseling, for the treatment of diabetes. In order to be covered, such services must be prescribed and certified by a Physician as Medically Necessary, an provided by a Participating Physician, R.N., Dietitian, or Pharmacist who has completed a diabetes patient management program recognized by the American Council on Pharmaceutical Education and the State Board of Pharmacy in which the Provider practices. Services and supplies included under this provision will include: ► Blood glucose monitors, including monitors for the legally blind ► Test strips for blood glucose monitors ► Visual reading and urine test strips ► Injection aids ► Syringes and lancet ► Insulin pumps infusion devices, and Medically Necessary accessories ► Podiatric appliances for prevention of complications associated with diabetes ► Glucagon emergency kits Benefits for injectable insulin and oral hypoglycemic agents will also be available under Prescription Drug coverage.

Preventive Services	**Allergy Shots.** Benefits are available as specified in the Schedule of Benefits on behalf of Covered Persons. **Preventive Care.** Benefits are available as specified in the Schedule of Benefits on behalf of Covered Persons six years of age or older for physical examinations subject to annual Plan maximums. Female Covered Persons may elect to have such exam provided by an Obstetrician/ Gynecologist. **Well Child Care.** Benefits include history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunization and laboratory tests, in keeping with prevailing medical standards, for Covered Persons under six years of age, subject to the following guidelines: ► Immunizations/vaccinations/booster shots: -Diphtheria -Tetanus -Haemophilus Influenza Type B -Mumps -Hepatitis B -Pertussis -Polio -Rubella -Pneumococcus
Routine Nursery Care	Routine Nursery Care is room, board, and other normal care for which a Hospital makes a charge. This coverage is provided only if a parent is a Covered Person who was covered under the Plan at the termination of the Pregnancy, and the Child is an eligible Dependent and is neither injured nor ill.
Reconstructive Breast Surgery	Reconstruction of the breast on which a mastectomy (other than a lumpectomy) has been performed, including ► All stages of reconstruction of the breast on which the mastectomy has been performed. ► Surgery and reconstruction of the other breast to produce a symmetrical appearance ► Prostheses and physical complications of mastectomy, including lymphedemas Such coverage shall be provided in a manner determined in consultation with the patient and the attending Physician. It is subject to the same Annual Deductibles and Coinsurance requirements as are provided with respect to other Covered Services.

What services, supplies or charges aren't covered?

The Plan does not provide benefits for the following services, supplies, or charges:

- Services or supplies not prescribed or performed by a Physician or Other Professional Provider.
- Services or supplies that the Plan determines are not Medically Necessary.
- Services provided before your coverage begins.
- A drug, device, or medical treatment or procedure that is Experimental or Investigational (coverage under the Plan may be changed when a certain procedure is no longer considered Experimental and Investigative).
- Any work related Illness or Injury (unless resulting from self-employment not subject to workers' compensation insurance requirements).
- Services or supplies furnished without cost under the laws of any government.
- Illness or Injury resulting from war (occurring after coverage begins).
- Services for which the patient is not required or legally obligated to pay.
- Services or supplies received in a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust, or similar group.
- Services, supplies, or prosthetics primarily to improve appearance or which are provided in order to correct or repair the results of a prior surgical procedure the primary purpose of which was to improve appearance.
- Self-treatment or services provided by any person related to you by blood or marriage, including Spouse, parent, Child, legal guardian, aunt, uncle, stepchild, or any person who resides in a Covered Person's immediate household.
- Services rendered by other than a Hospital, Physician, Other Professional Provider, or Other Provider specified in the Plan.
- Personal hygiene and convenience items (such as air conditioners, humidifiers, or physical fitness equipment).
- Telephone consultations, charges incurred due to failure to keep a scheduled appointment, or charges to complete a claim form or to provide medical records.
- Hospital admissions that are primarily for diagnostic studies.
- Custodial Care, such as help in walking, getting in or out of bed, or any service that could be performed by a family member or non-professional personnel.
- Routine adult immunizations, and screening examinations including x-rays made without film, except as otherwise specified.
- Services or supplies for dental care, except as specified.
- Eyeglasses, contact lenses, and examinations for and the fitting of eyeglasses and contact lenses.
- Hearing aids and examinations for and the fitting of hearing aids (for the purpose of the Plan, "hearing aids" will include any procedure or device designed to restore or enhance the patient's ability to hear, including, but not limited to, audiant bone conduction, electromagnetic, and/or surgically implanted devices).
- Hospital admissions primarily for physical therapy (physical therapy may be covered where there is another primary diagnosis).
- Surgery to change sex, and related services.
- Procedures, drugs or biologicals for, or in connection with, artificial insemination, in vitro fertilization, or any other service or supply intended to create a Pregnancy (however, a service or supply may be covered if it is provided to treat an Illness or underlying medical condition resulting in infertility. Services which may be covered under this provision include:
  - treatment to correct a previous tubal Pregnancy, and
  - treatment by ovulatory drugs (such as clomid) or hormonal treatment used primarily to treat irregular menstrual periods).
- Services covered under Medicare, except as required by applicable state or federal law.
- Non-medical self-care or self-help training.
- Any services or supplies designed to correct refractive errors of the eyes, except Surgery for removal of cataracts (including surgical implant of a prosthetic lens following cataract extraction).
- An artificial heart or any other artificial organ, or any associated expense.

- Services or supplies for the reversal of sterilization.
- Services or supplies incurred after a Concurrent Review determines the services and supplies are no longer Medically Necessary.
- Charges in excess of the Usual and Customary Charges or in excess of the Plan's Maximum Allowable Charges for a service or supply.
- Services rendered for or in connection with physical therapy that consist primarily in the application, supervision, or direction in the use of exercise or physical fitness equipment--whether or not such services are rendered by an eligible Provider.
- Any balance of charges, Deductibles, Copayments, or Coinsurance resulting from a Covered Person's failure to comply with applicable requirements of any other individual or group plan, including Precertification, second surgical opinion consultation, Outpatient Surgery, or Concurrent Review programs.
- Services or supplies for Inpatient treatment of bulimia, anorexia, or other eating disorders that consist primarily of diet and weight monitoring and educational services.
- Services or supplies in connection with treatment of any obesity other than morbid obesity.
- Any charges for services and supplies rendered to a Covered Person that require the approval of the Plan Administrator, where such approval is not given.
- Services required as a result of the commission of a felony by a Covered Person or the attempt to commit a felony.
- Services or supplies rendered prior to the Effective Date or after coverage is terminated, except as otherwise specified.
- Room, board, and general nursing care rendered on the date of discharge, unless both admission and discharge occur on the same day.
- A second or third surgical opinion rendered by a Physician in the same medical group or practice as (a) the Physician who initially recommended the Surgery, or (b) the Physician who rendered either the second or third surgical opinion.
- Staff consultations required by Hospital rules.
- Prosthetic appliances or items of Durable Medical Equipment to replace those which were lost, damaged, or stolen or prescribed as a result of improved technology.
- Exercise or athletic equipment, saunas, whirlpools, air conditioners, water purifiers, humidifiers, home modifications or improvements, any motorized vehicles (except electric wheelchairs), swimming pools, tanning beds, and recreational equipment.
- Dental appliances, including those used for correction of jaw malformations, except where prescribed as part of a surgical procedure necessary to restore a major bodily function.
- Inpatient private duty nursing in an acute care Hospital, except as specified in the Plan.
- Over-the-counter drugs (not requiring a prescription), unless required by law or specifically designated as covered under the Plan; prescription devices, vitamins, except those which by law require a prescription; Viagra and other lifestyle drugs, cosmetic drugs, and/or prescription drugs dispensed in a Physician's office.
- Certain prescription drugs for which there is an over-the-counter drug alternative.
- Any care or treatment involving acupuncture, unless specifically included in the Medical Schedule of Benefits (Appendix A).
- Replacement of implanted cataract lenses.
- Court-ordered treatment of a Covered Person unless benefits are otherwise payable.
- Medical treatment for which you have been reimbursed under a mass tort or class action lawsuit, settlement or judgment.

Notwithstanding the foregoing, benefits that would otherwise be provided for the treatment of an Injury will not be excluded solely because the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Claims will be processed based upon information available at the time they are received by the Plan Administrator. The Plan Administrator may elect to provide benefits for services pending a determination of whether such services are excluded without waiving the exclusions listed above. In the event that the Plan Administrator determines that services or supplies are excluded, the Plan will be entitled to recover any amount paid for such services and supplies from the Provider or you. You must produce and deliver to the Plan Administrator all assignments and other documents as requested by the Plan Administrator for the purpose of enforcing rights under this provision; the failure to do so may result in a rescission of all future benefits under the Plan.

Dental Care Benefits

What are the Plan's dental care benefits?

Dental care benefits are payable for Covered Charges in excess of the dental Annual Deductible or for Covered Charges not subject to a dental Annual Deductible incurred while covered under the Plan, subject to the Maximum Lifetime Benefit limits, Coinsurance, and other requirements set forth in the Dental Care Schedule of Benefits.

What is the basis for payment of eligible dental care benefits?

All Covered Charges are based on Usual and Customary Charges for Covered Services. Covered Services must be performed or prescribed by a Dental Care Provider and must be necessary and appropriate according to generally accepted dental standards. Dental care benefits provided by this Plan are based on materials and treatment methods that provide a professionally adequate result. If more than one treatment procedure is appropriate, the Plan will pay the least costly alternative as a Covered Charge.

Can the Plan provide a predetermination of benefits?

If dental services are expected to be $300 or more, a Covered Person should determine in advance what will be covered by the Plan. To have benefits predetermined, the Dental Care Provider should submit a claim form to the Plan Administrator or its designee describing the proposed treatment and the cost. The Plan Administrator or its designee will then estimate benefits and advise the patient and the Dental Care Provider what the Plan will pay before treatment begins. Predetermination is not necessary for dental services reasonably expected to be under $300; however, all similar dental services must be aggregated on one bill for this purpose.

Is there an Annual Deductible?

The dental Annual Deductible is applicable to Basic and Major treatment expenses only as noted below. No Annual Deductible is applied for preventive or orthodontia treatment expenses.

What Dental charges are covered?

Diagnostic/Preventive	► Two oral exams each calendar year (every six months) ► Full mouth x-rays once every 36 months ► Four bitewing x-rays each calendar year ► Cleaning and scaling the teeth twice each calendar year (every 6 months) ► Space maintainers for covered Dependents under age 19 ► Emergency palliative treatment (temporary relief of pain or discomfort) ► Fluoride treatments for covered Dependents under age 19
Basic	► Fillings (amalgam, silicate, acrylic, synthetic porcelain, or composite) ► Extractions ► General anesthesia and its administration when it is Medically Necessary for oral surgery ► Repair or recementing of crowns, inlays, onlays, dentures, or bridgework ► Stainless steel crowns for Dependent Children under age 19 ► Sealants (one-time application) for Dependent Children under age 19

Major	▸ Root canal treatment ▸ Treatment of periodontal disease and other diseases of the gums and tissues ▸ Oral surgery ▸ Initial installation of fixed bridgework ▸ Initial installation of partial removable or full removable dentures ▸ Replacement of an existing removable denture or fixed bridgework because of a loss of a natural tooth (or teeth) after the existing appliance was installed ▸ Replacement of an existing removable denture or fixed bridgework because it is no longer usable and was installed at least five years prior to its replacement ▸ Replacement of an existing immediate temporary full denture with a new permanent full denture because the existing denture cannot be made permanent if installed within 12 months after the existing denture was installed ▸ Inlays, onlays and crowns ▸ Implants
Orthodontia	For Dependent Children under age 19 only

Dental Care Schedule of Benefits

Refer to Schedule of Benefits.

What dental services or supplies aren't covered?

No benefits are payable for services, supplies, treatment, or charges:

- Received before coverage under this Plan began.
- Not performed by a licensed Dental Care Provider.
- For medical (dental) care benefits provided under another plan of the Employer.
- Payable under another plan of the Employer.
- For cosmetic surgery, except for treatment of a congenital defect of a newborn Dependent Child.
- For repair of an orthodontic appliance, or replacement or duplication of a lost, missing or stolen crown, bridge, denture, orthodontic appliance or other prosthetic device.
- Covered by any workers' compensation, occupational disease, or employer liability laws.
- Considered to be Experimental or Investigative by generally accepted dental standards.
- For dental Injury or disease caused by war or act of war, or voluntary participation in criminal activities (but not an Injury resulting from an act of domestic violence or a medical condition).
- For dental Injuries received while participating in any hazardous nonoccupational activities such as bungee jumping, motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, sky diving, hang gliding, or driving or riding in any speed contest (but not an Injury resulting from a medical condition or act of domestic violence).
- For which a Covered Person is not required to pay or for which no charge would be made if there were no coverage under this Plan.
- For periodontal splinting.
- For oral care instructions or decay prevention materials other than fluorides.
- Adjustments to dentures or bridgework within six months after their installation if made by the same Dental Care Provider who installed them.
- That are not expressly covered herein.

- In excess of the Usual and Customary Charges, or in excess of the Plan limits shown in the Dental Care Schedule of Benefits.

What about ongoing treatment when dental coverage ends?

If coverage ends, no additional dental expenses incurred will be payable, except for:

- Prosthetic devices, if the Dental Care Provider has prepared the abutment teeth and made impressions before coverage ends and installs the devices within 30 days after coverage ends.
- Crowns, if the Dental Care Provider has prepared the teeth for the crowns before coverage ends and installs the crowns within 30 days after coverage ends.
- Root canals, if the Dental Care Provider has opened the teeth before your coverage ends and completes the treatment within 30 days after coverage ends.

Vision Care Benefits

Who is eligible for Vision Care Benefits?

Individuals who satisfy the eligibility requirements under the Plan as listed under Eligibility and Enrollment, except for individuals employed at facilities listed on Appendix E.

What vision services are covered?

Vision care benefits are provided through a separate fully-insured plan called the Vision Service Plan ("VSP") and are governed solely by the terms of such plan. The following summary is provided for your reference, but it does not affect the benefits provided or other terms of the plan. Certain vision benefits that are not covered by the VSP may be covered by the Plan, including treatment for accidental Injury. VSP's covered services and materials include:

BENEFIT	FREQUENCY	CO-PAY	FROM VSP DOCTOR	FROM NON-VSP DOCTOR
Examination	12 months[1]	$15 for covered benefit (services & materials).	Covered	Covered up to $40
Lenses[2]	12 months[1]		Covered	Covered up to $31/single vision Covered up to $47/lined bifocal Covered up to $61/lined trifocal Covered up to $80/lenticular
Frames[2]	24 months[1]		Covered up to $130	Covered up to $45
Contact Lenses[3,4] (not Medically Necessary)	12 months[1]	None	Covered up to $130	Covered up to $105
Contact Lenses (Medically Necessary)[5]	12 months[1]	None	Covered	Covered up to $210
Low Vision[6]	24 months[1]	25% of authorized benefit	Covered up to $1000 (excluding co-pay)	Covered up to limit for VSP Doctor benefit

[1] Based on plan year beginning January 1.
[2] The Plan provides a 20 percent discount on non-covered complete pairs of prescription glasses.
[3] Patients choosing contacts are deemed to use their eligibility for a frame and lenses.
[4] The Plan includes a 15 percent discount off of the VSP doctor's professional services when buying contact lenses. A contact lens exam is performed in addition to your routine eye exam to check for eye health

risks associated with improper wearing or fitting of contacts.

[5] Medically necessary contact lenses must be prescribed by a VSP doctor for certain conditions. The VSP doctor must get prior approval from VSP for Medically Necessary contact lenses.

[6] The Low Vision benefit is available to Covered Persons who have severe visual problems that are not correctable with regular lenses and is subject to prior approval by the VSP Optometric Consultants.

Are there any Copayments required?

Yes. Amounts are indicated in the above chart.

How do I use VSP?

The services above may be secured from any VSP member Vision Care Provider. If the services are provided by a VSP member Physician, there is no expense (except the $15 Copay) for required services or materials. You will be charged for certain cosmetic or elective eyewear options, such as oversize lenses, a frame exceeding the allowable maximum, or tinted lenses other than Pink #1 and Pink #2.

To use VSP, simply make an appointment with a VSP member Vision Care Provider. The VSP member Vision Care Provider will contact VSP for patient authorization and coverage based on the patient's social security number.

To locate a VSP Vision Care Provider, a Covered Person should consult VSP's on-line Vision Care Provider directory service at www.vsp.com, or call 1-800-877-7195.

Does the plan provide for non-member Vision Care Provider benefits?

For non-VSP Vision Care Provider's, VSP will reimburse up to the amount allowed under the Plan's non-member Vision Care Provider reimbursement rate. For reimbursement of non-VSP Vision Care Provider charges, the following information must be submitted to VSP:

- Vision Care Provider's bill, including a detailed list of the services received.
- Patient's name, Social Security Number, address and phone number.
- Employer's name.
- Employee's name, date of birth, phone number, and address.
- Employee's relationship to the patient.

Original documents must be sent to:

Vision Service Plan
Out-of-Network Claims Department
P.O. Box 997105
Sacramento, CA 95899-7105

VSP will subtract the Annual Deductible from the actual charges and then reimburse the employee for the services up to the amounts shown in the Schedule of Benefits. There is no assurance that the benefits provided will be sufficient to cover the Vision Care Provider's services or the materials in full.

How do I file a complaint or grievance with VSP?

If a Covered Person ever has a question or problem, the Covered Person's first step should be to call VSP's Member Services at 1-800-877-7195. Member Services will make every effort to answer the Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from Member Services. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Covered Persons also have the right to submit written comments or supporting

documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within 30 days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than 120 days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within 30 days, a letter will be sent to the Covered Person to indicate VSP's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

How are claim payments and denials handled by VSP?

To the extent it is consistent with the Submission of Claims section of this Plan document, VSP will process claim payments and denials according to the following procedure:

VSP will pay or deny claims within 30 calendar days of the receipt of the claim from a Covered Person or the Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than 15 calendar days.

If a Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within 180 days after receipt of such notice of denial of a claim, Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. The Covered Person or the Covered Person's authorized representative should submit all requests for appeals to:

Vision Service Plan
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

VSP's determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within 30 calendar days after receipt of a request for appeal from the Covered Person or the Covered Person's authorized representative.

If the Covered Person disagrees with VSP's determination, he/she may request a second level appeal within 60 calendar days from the date of the determination. VSP shall resolve any second level appeal within 30 calendar days.

When the Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. The Covered Person should contact the U.S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA Section 502(a)(l)(B), the Covered Person has the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and the Covered Person disagrees with the outcome.

The foregoing terms of the VSP are subject to the terms of an insurance policy between VSP and CHS. In the event of any conflict between this section and the policy, the terms of the policy will govern. This section is not intended and shall not be construed to provide any benefits greater than those provided under the policy. Defined terms within this section shall have the meanings provided for under the policy in the event that the terms set forth in the Definitions section of this document conflict with the terms provided for under the policy.

Submission of Claims

Are claim forms required?

In order to receive any Plan benefits, you or your Providers must file written claims for medical, dental, or vision care expenses. Your Human Resources Department can provide the applicable claim forms and the address for submission of claims.

How long after services are provided will the Plan consider the charges?

Claims submitted for payment within 12 months of the date of service will be considered by the Plan for payment of benefits. Claims should be submitted when treatment is concluded or, if treatment is ongoing, accumulated expenses representing a significant sum at least equal to the Annual Deductible.

What information needs to be submitted in order for my claims to be processed?

Bills from Providers serve as evidence to support claims. If the attending Physician's or other Provider's statement on the claim form does not provide full details, itemized bills must be attached to the claim form. Each bill submitted must contain all of the following information:

- Employee's full name.
- Patient's full name and relationship to Employee.
- Provider's name, address and tax identification number.
- Date(s) the service was rendered or the purchase was made.
- Nature of the treatment, Illness, or Injury.
- Type of service or supply furnished with diagnosis and procedure codes.
- Itemized charges.

What are the Plan's claims procedures?

In the case of a failure by you or your authorized representative to follow the Plan's procedures for filing a Pre-service Claim, you or your authorized representative will be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification will be provided to you or your authorized representative, as appropriate, as soon as possible, but not later than 5 days (24 hours for Urgent Care claims) following the failure. Notification may be oral, unless written notification is requested by you or your authorized representative. Except as otherwise provided in this Plan, if a claim is wholly or partially denied, the Plan Administrator will notify you, as described below, of the Plan's adverse benefit determination. (See the "Summary of Benefit Claims Procedures Deadlines" for an overview of the time limits pertaining to claims submission, benefit determinations, and review of adverse benefit determinations.)

In the case of a claim involving Urgent Care, the Plan Administrator or its designee (i.e., a third-party administrator) will notify you of the Plan's benefit determination (whether adverse or not) as soon as

possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator or its designee will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan (as noted above), of the specific information necessary to complete the claim. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination will be made as provided below. The Plan Administrator or its designee will notify you of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of: the Plan's receipt of the specified information, or the end of the period afforded you to provide the specified information.

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. The Plan Administrator or its designee will notify you, as provided below, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Any request by you to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care will be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator or its designee will notify you of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving Urgent Care or not, and appeals of any adverse benefit determination will be made as provided below.

In the case of a claim not described above, the Plan Administrator or its designee will notify you of the Plan's benefit determination in accordance with the following, as appropriate:

- **Pre-service Claims**. In the case of a Pre-service Claim, the Plan Administrator or its designee will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator or its designee both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this section will be made as provided below.

- **Post-service Claims**. In the case of a Post-service Claim, the Plan Administrator or its designee will notify you, as provided below, of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator or its designee both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will

specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

The Plan Administrator or its designee will provide you with written or electronic notification of any adverse benefit determination. Any electronic notification will comply with the standards imposed by 29 C.F.R. 2520.104b-1(c)(1)(i), (iii), and (iv). The notification will set forth, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse determination.
- Reference to the provisions on which the determination is based.
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.
- If the adverse benefit determination is based on a medical necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- In the case of an adverse benefit determination concerning a claim involving Urgent Care, a description of the expedited review process applicable to such claims.

In the case of an adverse benefit determination concerning a claim involving Urgent Care, the information described above may be provided to you orally within the time frame prescribed above, provided that a written or electronic notification in accordance with this section is furnished to you not later than 3 days after the oral notification.

Is there an appeal process for denied claims?

You will have 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination. The third-party administrator may sometimes refer to this appeal procedure as a "grievance" procedure. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits. You will also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. The review of your claim will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition, the review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the appropriate fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The review will provide for the identification of medical or

vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination. The health care professional engaged for purposes of a consultation during the claims review process will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

In the case of a claim involving Urgent Care, a request for an expedited appeal of an adverse benefit determination may be submitted by you orally or in writing. All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile, or other available similarly expeditious method. In the case of a claim involving Urgent Care, the Plan Administrator or its designee will notify you of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination by the Plan.

In the case of a Pre-service Claim, the Plan Administrator or its designee will notify you of the Plan's benefit determination on review not later than 30 days after receipt by the Plan of your request for review of the adverse determination. The appeal will be reviewed by the Plan's third-party administrator (claims administrator) or such other persons or entities designated by the Plan Administrator or its designee.

In the case of a Post-service Claim, the Plan Administrator or its designee will notify you of the Plan's benefit determination on review with respect to any one of the two appeals provided under the Plan not later than 30 days after receipt by the Plan of your request for review of the adverse determination. For Post-service Claims, the first appeal will be reviewed by the Plan's third-party administrator (claims administrator) or such other persons or entities designated by the Plan Administrator or its designee. The second appeal will be reviewed by the Claims Review Committee or such other persons or entities designated by the Plan Administrator or its designee.

The Plan Administrator or its designee will provide you with written or electronic notification of a Plan's benefit determination on review. Any electronic notification will comply with the standards imposed by 29 C.F.R. 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification will set forth, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse determination.
- Reference to the provisions on which the benefit determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under section 502(a) of ERISA.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request.
- If the adverse benefit determination is based on a medical necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or your State insurance regulatory agency.

An authorized representative may be permitted to act on your behalf when pursuing a benefit claim or an appeal of an adverse decision. In situations involving a need for Urgent Care, a health care professional with knowledge of your medical condition may act as your authorized representative. In accordance with Section 503 of Title I of ERISA, the Plan Administrator or its designee may designate one or more persons (including a committee, the members of which will be designated by the Plan Administrator or its designee) under the Plan, each with complete authority to perform the duties described above of the Plan Administrator, including the review of all denied claims for benefits under the Plan (including, but not limited to, the denial of certification of the medical necessity of treatment). In exercising its fiduciary responsibilities, the Plan Administrator will have sole, exclusive, and final discretionary authority to determine whether and to what extent Covered Persons and beneficiaries are entitled to any benefits under the Plan and to construe disputed, ambiguous, vague, and/or doubtful Plan terms. The Plan Administrator will be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

SUMMARY OF BENEFIT CLAIMS PROCEDURES DEADLINES

	Urgent Care Claims	**Pre-Service Health Claims**	**Post-Service Health Claims**
Plan Notice of Improper Claim (Failure to Follow Plan Procedures)	As soon as possible but no later than 24 hours after failure	As soon as possible but no later than 5 days after failure	N/A
Plan Notice of Incomplete Claim (Failure to Provide Sufficient Information)	24 hours after receipt of claim	N/A	N/A
Deadline to Complete Claim	48 hours after receipt of notice of incomplete claim	45 days after receipt of extension notice of failure to provide necessary information	45 days after receipt of extension notice of failure to provide necessary information
Plan Notice of Claim Decision	(1) 72 hours after receipt of claim; or (2) in the case of an incomplete claim, 48 hours after the earlier of (i) receiving completed claim, or (ii) after the 48-hour deadline (noted above)	15 days after receiving the claim; extended for 15 days if plan provides an extension notice during initial 15-day period	30 days after receiving the claim; extended for 15 days if plan provides an extension notice during initial 30-day period
Plan Notice of Appeal Decision	72 hours after receiving the appeal (note: one level of appeal)	30 days after receiving the notice of appeal; (note: one level of appeal)	30 days after receiving the first notice of appeal; 30 days after receiving the second notice of appeal (note: two levels of appeal)

How does the Plan process Subrogation Claims, its Right of Reimbursement, and its Right of Offset? What are the Plan's rights in your recovery from a third party?

A third party (including an insurer or other employee benefit plan) may be liable for, legally responsible for, and/or may pay for expenses incurred by a Covered Person for an Illness, a sickness, or a bodily Injury. Benefits may also be payable or paid under this Plan for such expenses. When this happens, the Plan Administrator may, at its option:

- Take over the Covered Person's right to receive payment of benefits from the third party (including an insurer or other employee benefit plan) ("Right of Subrogation"). The Plan has the right to be subrogated to the legal rights the Covered Person has or may have to recovery of any payments made by the Plan for medical expenses, however classified or denominated, where the Covered Person's Illness, sickness, or bodily Injury resulted from the action, omission, or fault of a third party, in whole or in part, and the Plan may as a result take over and assume the Covered Person's right to receive payment of benefits from such third party (and any insurer or other employee benefit plan). The Plan has the right to recover amounts equal to its payments for medical expenses by suit, settlement, or otherwise from the insurer or other employee benefit plan of the third party; from the person who caused the Illness, sickness, or bodily Injury or his or her insurance or other employee benefit plan; or any other source such as uninsured or underinsured motorist coverage. This Right of Subrogation is provided with respect to all recoveries received from any third party (whether by lawsuit, settlement, or otherwise) that is due to the Plan for the benefits provided under the Plan. The Covered Person must:

- Promptly notify the Plan Administrator of any Illness, sickness, or bodily Injury for which the third party (or any insurer or other employee benefit plan) may be liable or legally responsible whether resulting from an accident or otherwise or from which payments have been or may be made.
- Promptly transfer to the Plan any rights he or she may have to take legal action against the third party (or any insurer or other employee benefit plan) with respect to benefits paid by the Plan.
- Cooperate fully with the Plan Administrator in asserting the Plan's Right of Subrogation. The Covered Person must arrange for counsel or other representative with respect to a settlement with any third party to contact the Plan in advance of any settlement. The Covered Person must supply the Plan with all information and sign and promptly return all documents requested by the Plan Administrator in order to carry out the Plan's Right of Subrogation.
- Obtain the consent of the Plan Administrator before settling or otherwise compromising any claim against the third party (or insurer or other employee benefit plan).

- In addition, recover from the Covered Person any benefits paid under the Plan that the Covered Person is or may be entitled to receive from the third party (or any insurer or other employee benefit plan) ("Right of Reimbursement") first regardless of whether any recovery is characterized as a recovery for medical expenses or otherwise. The Plan will have a first lien (equitable in nature) with priority upon any recovery, whether by settlement, judgment, or otherwise, that the Covered Person receives from (i) the third party; (ii) the third party's insurer(s); (iii) any other insurer or other employee benefit plan of the Covered Person (including any uninsured or underinsured motorist coverage insurer); or (iv) guarantor(s). This lien will be for the amount of benefits paid by the Plan for the treatment of the Illness, sickness, or bodily Injury for which the third party is liable or legally responsible. This Right of Reimbursement is provided with respect to all recoveries from a third party (whether by lawsuit, settlement, or otherwise) that is due to the Plan for the benefits provided under the Plan. The Covered Person must cooperate fully with the Plan Administrator in asserting the Plan's Right of Reimbursement, sign and return to the Plan Administrator any documents requested by the Plan Administrator in order to enforce the Plan's Right of Reimbursement or otherwise, and take no action without the express written consent of the Plan Administrator that would prejudice the Plan's Right of Reimbursement. If the Covered Person makes any recovery as described above and fails to reimburse the Plan fully for any benefits paid under this provision, he or she will be

required to turn over to the Plan any funds in the possession, custody, or control of the Covered Person (or any person or entity under the direction or control of the Covered Person) received from the third party (or insurer or other employee benefit plan) and such funds shall be held for the benefit of the Plan. The Covered Person will also be required to turn over to the Plan any amount of money recovered through judgment or settlement from any third party (or insurer or other employee benefit plan) up to the amount of benefits provided by the Plan and until such time such funds shall be held for the benefit of the Plan.:

- The Plan shall have all right, title, interest, and ownership in any recovery a Covered Person receives for any benefits paid under the Plan regardless of whether such recovery is characterized as a recovery for medical expenses or otherwise, and, as a condition of participation and any receipt of benefits under the Plan, the Covered Person must and does grant all right, title, interest, and ownership in such recovery to the Plan to the full extent of any benefits provided to the Covered Person under the Plan. The Covered Person shall grant such right, title, interest, and ownership so that the Plan Administrator may pursue, to the fullest extent permitted by law, a claim in equity, including a claim to recover on an equitable lien by agreement or such other claims as are permissible under Section 502(a)(3) of ERISA or otherwise.
- The Plan also has the right to intervene in any action brought by or for the benefit of the Covered Person, whether in state or federal court, to exercise its Rights of Subrogation and Reimbursement, and the Covered Person, by its participation in the Plan and/or receipt of benefits under the Plan, consents to the intervention of the Plan in any such action. The Plan shall have the right to commence an action in state or federal court to effect its Rights of Subrogation and Reimbursement, and the Covered Person shall not raise any objection or defense to such action. The Plan shall have the right to obtain a temporary restraining order, injunction, or other equitable relief to enforce its Rights of Subrogation and Reimbursement, and the Covered Person shall not raise any objection or defense to such action. The Plan shall have the right to enforce an equitable lien by agreement with respect to its Rights of Subrogation and Reimbursement. In the event the Covered Person does not fully cooperate with the Plan Administrator in asserting the Plan's Right of Reimbursement, the Plan shall be entitled to collect, in addition to all other rights, the reasonable attorneys' fees and costs incurred by the Plan in asserting such Right of Reimbursement.
- The Plan will not be obligated or responsible for the payment of any attorneys' fees and/or costs incurred by the Covered Person or any other party. The "common fund rule" and any similar common law or statutory doctrines will not apply with respect to any recovery from a third party. Also, the Plan may enforce the Right of Reimbursement regardless of whether the Covered Person is made whole or restored financially; therefore, the "make whole rule" and any similar statutory or common law doctrines will not apply with respect to any recovery from a third party (including any insurer or other employee benefit plan). Accordingly, the Plan's recovery shall not be reduced, affected, or eliminated because the Covered Person has not received the full damages claimed by the Covered Person. The common fund doctrines, doctrines of comparative or contributory negligence, collateral source rule, and any similar or other doctrines or rules shall not apply with respect to the Rights of Subrogation and Reimbursement.
- The Plan reserves the right to deduct from any pending and/or subsequent claims for payment under the Plan as an offset any amounts the Covered Person may be entitled to under the Plan to the extent necessary to recover amounts owed by or with respect to the Covered Person pursuant to the Rights of Subrogation and Reimbursement (a "Right of Offset").
- For the purposes of this section, the rights of the Plan may be asserted against, and the obligations of the Covered Person shall be extended to, the Covered Person's heirs, the Covered Person's legal representative, and/or the Covered Person's parents or legal guardian (if the Covered Person is a minor).

Does the Plan coordinate benefits with other plans?

The purpose of this Plan is to help you pay for Covered Services, subject to the limits set forth in the Plan. If you have coverage under another plan, benefits provided under this Plan could exceed the actual expenses incurred if such benefits were not coordinated with the benefits provided under this Plan. Therefore, this Plan expressly provides that the combined benefits payable under this Plan and the other plan will not exceed the benefits provided under this Plan. To coordinate benefits, it is necessary to determine in what order the benefits of various plans are payable. This is determined in accordance with the following chart in the following order:

No Coordination of Benefits Provision	If the other plan has no coordination of benefits provision, that other plan is primary.
Employee/Dependent	The plan covering a person as an employee is primary over the plan covering the person as a dependent.
Active/Inactive Employee	The plan covering a person as an active employee is primary over the plan covering the person as a laid off or retired employee.
Dependent Child/Parents not Separated or Divorced	If both plans cover the person as a dependent child, the plan of the parent whose birthday (excluding the year of birth) falls earlier in the year will be primary. If the parents have the same birthday (excluding the year of birth), the plan that has covered the person for the longer period of time is primary.
Dependent Child/Parents Separated or Divorced	• If two or more plans cover the patient as a dependent child of divorced or separated parents, benefits are determined in this order: • first, the plan of the parent with custody is primary; • then, the plan of the spouse of the parent with custody is primary; • last, the plan of the parent without custody is primary. However, if there is a court order that specifically states that one parent must provide the child's health care, that parent's plan is primary.
Longer/Shorter Length of Coverage	If none of the above rules determine the order of payment, the plan that has covered the person for the longer period of time is primary. In any case, if this plan is secondary, it will not provide benefits greater than if it had been primary.

If the benefits of this Plan are payable before those of the other plan (that is, this Plan is primary), the benefits of this Plan will be payable as provided for in this Plan. However, if the benefits of the other plan are payable before those of this Plan (that is, the other plan is primary), the benefits of this Plan will be reduced so that the combined benefits under this Plan and the other plan will not in any case be more than the benefits available under this Plan for the Covered Charges for Covered Services that are incurred.

For the purposes of this provision, a plan other than this Plan shall include any plan providing benefits or services for or by reason of health care or treatment including, but not limited to, any group or individual insurance coverage, any union plan, and any governmental plan (except Medicare as required by law). However, a plan other than this Plan shall not include any plan that is primarily intended by the insurer as an income replacement plan, does not have a coordination of benefits provision, and limits coverage to certain specified illnesses and/or injuries.

To administer this Plan, the Plan Administrator reserves the right to provide or obtain any data needed to determine the benefits payable under this provision and recover any sum paid above the amount that is required to be paid by the Plan.

How does the Plan administer Qualified Medical Child Support Orders?

The Plan Administrator will determine whether medical child support orders are qualified in accordance with applicable Employee Retirement Income Security Act ("ERISA") requirements. A Qualified Medical Child Support Order ("QMCSO") is a medical child support order that creates or recognizes an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Covered Person or beneficiary is eligible, and which the Plan Administrator has determined meets the qualification requirements contained in this section. An alternate recipient means any Child of an Eligible Employee who is recognized under a medical child support order as having a right to enroll in a group health plan with respect to the Eligible Employee.

To be qualified, a medical child support order must clearly specify all of the following:

- The name and the last known mailing address (if any) of the Eligible Employee and the name and mailing address of each alternate recipient covered by the order.
- A reasonable description of the type of coverage to be provided by the plan to each alternate recipient, or the manner in which such type of coverage is to be determined.
- Each period to which such order applies.
- Each plan to which such order applies.

A QMCSO must not require the Plan to provide any type or form of benefits or any option not otherwise provided under the Plan except to the extent necessary to meet the requirements described in Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

Upon receipt of a Medical Child Support Order, the Plan Administrator will:

- Promptly notify in writing the Eligible Employee, each alternate recipient covered by the order, and each representative for these parties of the receipt of the Medical Child Support Order. Such notice will include a copy of the order and these QMCSO procedures for determining whether such order is a QMCSO.
- Permit the alternate recipient to designate a representative to receive copies of notices sent the alternate recipient regarding the medical child support order.
- Within a reasonable period after receiving a medical child support order, determine whether it is a qualified order and notify the parties indicated in subsection (a) of such determination.
- Ensure the alternate recipient is treated by the Plan as a beneficiary for ERISA reporting and disclosure purposes, such as by distributing to the alternate recipient a copy of the Summary Plan Description and any subsequent Summaries of Material Modifications generated by a Plan amendment.

If I work after age 65 or become qualified for Medicare, am I still covered?

Yes. Active Employees age 65 and over and their dependent Spouses age 65 and over who are covered under this Plan are entitled to benefits under this Plan on the same basis as Active Employees and their dependent Spouses under age 65. This Plan will pay as the primary plan to Medicare described in the Coordination of Benefits section above.

This Plan will be the primary plan for totally disabled Employees and totally disabled Dependents who are covered under this Plan while entitled to Medicare disability benefits.

Definitions

The following definitions shall apply to the Plan unless otherwise defined in the Plan.

Active Employee means an Eligible Employee who is performing all of the duties of his or her job with the Employer on a full-time or part-time basis.

Active Work Requirement means performing all of the essential functions of your job with your Employer at your Employer's usual place of business or at another location designated by Employer. Job-related travel, jury duty, paid vacation, paid sick leave, approved family and medical leave, workers' compensation leave, or other Employer-approved leaves of absence (up to 90 days) are deemed to meet the Active Work Requirement. An absence from work due to any health factor (such as being absent from work on sick leave) shall be treated, for purposes of the Plan, as meeting the Active Work Requirement, provided that an Employee must begin work with the Employer before coverage becomes effective regardless of the reason for the absence. An Eligible Employee who is not working for any other reason fails to meet the Active Work Requirement.

Affiliated Employer means any an employer in the same controlled group as CHS/Community Health Systems, Inc.

Alcohol or Other Drug Dependency Treatment Center means a licensed facility that provides a written program, approved and monitored by a Physician, for the treatment of alcohol or other drug dependency and that is:

- affiliated by contract with a Hospital having an established patient referral system,
- accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association, and
- licensed, certified or approved by an appropriate state agency.

Ambulatory Surgical Facility means a licensed facility that:

- primarily performs surgical procedures on an Outpatient basis,
- does not provide Inpatient care,
- has an organized staff of Physicians and permanent facilities and equipment,
- may not be primarily used as an office or clinic for a Physician or other professional's private practice; and
- is a licensed institution.

Annual Deductible or **Deductible** means the initial amount of expenses for which no benefits will be paid. There is no Deductible for services provided at CHS hospitals. Before benefits can be paid in any Year, each Covered Person must meet the individual Annual Deductible shown in the Schedule of Benefits according to the coverage elected. When the aggregate Annual Deductible amount shown in the Schedule of Benefits for the coverage elected has been incurred by members of a Family, the Annual Deductibles of all members of that Family will be considered satisfied for that Year. See **Family Deductible.**

Birthing Center means any freestanding health facility, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must:

- be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located;
- provide facilities for obstetrical delivery and short-term recovery after delivery (no more than 24 hours);

- provide care under the full-time supervision of a Physician and either a R.N. or a licensed nurse-midwife; and
- have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Change of Status Event means any one or more of the events that permit a change of elections under the CHS Flexible Benefits Plan or as otherwise required by law.

Child or **Children** means your son, daughter, stepson, stepdaughter, eligible foster child, adopted child, or child for whom you have permanent legal and physical custody.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985.

Coinsurance means the amount stated as a percentage of allowable expense for a Covered Service that is the responsibility of the Covered Person. All medical Coinsurance amounts, except for penalties and non-Covered Charges, are accumulated towards satisfaction of the Plan's Annual Out-of-Pocket Maximum.

Complications of Pregnancy means conditions requiring Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, non-elective caesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible. Complications of Pregnancy does not include false labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Concurrent Review means the Plan Administrator's determination of whether continued Inpatient care, or a given level of service, is Medically Necessary. If, under such review, it is determined that continued Inpatient care is not Medically Necessary, the facility and the Physician will be notified in writing of a specific date after which benefits will no longer be paid.

Copayments mean the dollar amounts (specified in the Schedule of Benefits) for which a Covered Person is responsible when a particular service or supply is received. Copayments are not applied toward satisfaction of the Plan's Annual Deductible or Out-of-Pocket Maximum with respect to Medical Care.

Covered Charge means a charge for a Covered Service. A covered charge may also be referred to in the Plan as an eligible expense.

Covered Service means a Medically Necessary service or supply for which benefits may be available under the Plan.

Covered Person means an Eligible Employee or eligible Dependent who has completed all of the enrolment requirements of the Plan and is enrolled in the Plan

Creditable Coverage means individual or group health coverage of the Covered Person prior to his or her enrollment date that may be applied to reduce a Covered Person's Pre-existing Condition Waiting Period. Creditable Coverage includes coverage under COBRA, a health maintenance organization, Medicare, Medicaid (including coverage under a state program), the Federal Employee Health Benefit Plan, and/or a public, government, military or Indian Health Service health benefit program. A period of

up to 12 months (or up to 18 months for a HIPAA Late Enrollee) may be applied to reduce the Covered Person's applicable Pre-existing Condition Waiting Period. However, a period of coverage will not be counted for the purposes of reducing a Covered Person's Pre-existing Condition Waiting Period if there is a break in such coverage of 63 days or more during which the Covered Person was not covered under any Creditable Coverage.

Custodial Care means any services or supplies provided to assist an individual in the activities of daily living as determined by the Plan.

Deductible means the annual dollar amount of Covered Services specified in the Schedule of Benefits that must be incurred and paid by a Covered Person before benefits are payable for all or part of the remaining Covered Services. The Deductible will not apply toward satisfaction of the Out-of-Pocket and Family Out-of-Pocket Maximum(s).

Dental Care Provider means a licensed dentist or other dental care provider acceptable to the Plan Administrator for providing Covered Services with respect to dental care benefits under the Plan. Dependents are eligible Dependents of an Eligible Employee.

Dependent(s) means those dependents that are eligible under the Eligibility and Enrollment sections of this Plan.

Diagnostic Service means a procedure ordered by a Physician or Other Professional Provider to determine a specific condition or disease. Diagnostic Services include:

- x-rays and other radiology service
- laboratory and pathology services
- cardiographic, encephalographic and radioisotope tests

Doctor means a Physician, as defined herein.

Durable Medical Equipment means Medically Necessary and Appropriate medical equipment or items which, in the absence of Illness or Injury, are of no medical or other value to You. Items that can withstand repeated use in an ambulatory or home setting. Items that: (1) require the prescription of a Practitioner for purchase; (2) are approved by the FDA for the Illness or Injury for which it is prescribed; and (3) are not for Your convenience.

- Covered
  - Rental of Durable Medical Equipment – Maximum allowable rental charge not to exceed the total Maximum Allowable Charge for purchase.
  - The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment.
  - Supplies and accessories necessary for the effective functioning of Covered Durable Medical Equipment.
  - The replacement of items needed as the result of normal wear and tear, defects or obsolescence and aging.
- Exclusions
  - Charges exceeding the total cost of the Maximum Allowable Charge to purchase the equipment.
  - Unnecessary repair, adjustment or replacement of duplicates of any such equipment.
  - Supplies and accessories that are not necessary for the effective functioning of the Covered equipment.
  - Items to replace those which were lost, damaged, stolen or prescribed as a result of new technology.
  - Items which require or are dependent on alteration of home, workplace or transportation vehicle.

- Motorized scooters, exercise equipment, hot tubs, pools, saunas, "deluxe" or "enhanced" equipment. In all instances, the most basic equipment needed to provide the needed medical need will determine the benefit.

Eligible Employee means an Employee who meets the eligibility requirements under the Plan.

Eligibility Waiting Period means the period that must pass before a person becomes eligible for coverage under this Plan as specified under Eligibility and Enrollment and Appendix E.

Emergency means the sudden onset of a medical condition so severe that, without immediate medical attention, could reasonably be expected to cause:

- serious impairment to body functions;
- serious dysfunction of a bodily organ; or
- otherwise place the Covered Person's health in serious jeopardy.
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For behavioral health benefits, an Emergency is a sudden or rapidly escalating behavioral condition that, without immediate psychiatric or Substance Abuse attention, could reasonably be expected to cause serious emotional or physical dysfunction, or otherwise place the Covered Persons' or others' health and well being in serious danger.

An Emergency does not include treatment of a chronic condition in which subacute symptoms have existed over a period of time and would not be considered an Emergency unless symptoms suddenly became severe enough to require immediate medical assistance. Examples of Emergency conditions include: (1) severe chest pain; (2) uncontrollable bleeding; or (3) unconsciousness.

Emergency Admission means admission as an Inpatient in connection with an Emergency.

Emergency Services means health care services and supplies furnished in a Hospital that are required to determine, evaluate, and/or treat an Emergency until such condition is stabilized as directed or ordered by a Physician or Hospital protocol.

Employee means an employee of the Employer.

Experimental or **Investigational** means a drug, device, treatment, therapy, procedure, or other services or supplies which or for which, at the time it is requested, does not meet the definition of Medical Necessity and any of the following:

- Cannot be lawfully marketed without approval of the Food and Drug Administration (FDA) when such approval has not been granted at the time of use or proposed use.
- Is the subject of a current investigational new drug or new device application on file with the FDA.
- Is being provided pursuant to a Phase I or Phase II clinical trial or the experimental or research part of a Phase III clinical trial (provided, however, that participation in a clinical trial shall not be the sole basis for denial).
- Is being provided pursuant to a written protocol that describes among its objectives determinations of safety, toxicity, efficacy or effectiveness in comparison to under conventional alternatives.
- Is being delivered subject to the approval and supervision of an Institutional Review Board as required and defined by Federal regulations, particularly those of the FDA or the Department of Health and Human Services ("HHS").

- The Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within HHS has determined that the service or supply is either experimental or investigational or that there is insufficient data to determine if it is clinically acceptable.
- In the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings.
- In the predominant opinion of experts, as expressed in the published authoritative literature, further research is necessary in order to define safety, toxicity, efficacy, or effectiveness of that service compared with conventional alternatives, or
- The service or supply is required to treat a complication of an experimental or investigational service.

The Plan's Medical Director shall have discretionary authority to make a determination concerning whether a service or supply is experimental or investigational. If the Medical Director does not authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, the Medical Director shall rely upon any or all of the following, at his or her discretion:

- Your medical records,
- The protocol(s) under which proposed service or supply is to be delivered,
- Any consent document that You have executed or will be asked to execute, in order to received the proposed service or supply,
- The published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by You,
- Regulations or other official publications issued by the FDA and HHS,
- The opinions of any entities that contract with the Plan to assess and coordinate the treatment of Covered Persons requiring non-Experimental or Investigational services, or
- The findings of qualified evaluation entities.

Facility Other Provider means and includes:

- Freestanding Dialysis Facility
- Ambulatory Surgical Facility
- Skilled Nursing Facility
- Substance Abuse Treatment Facility
- Residential Treatment Facility
- Licensed Birthing Center

Family means the Employee and the eligible family members who are covered as Dependents under the Plan.

Family Coverage means coverage of an Eligible Employee and one or more eligible Dependents as defined in this Summary Plan Description.

Family Deductible means the annual maximum dollar amount of Covered Services stated in the Schedule of Benefits that must be incurred and paid by an Employee and his or her eligible Dependents before benefits are payable for all or part of the remaining Covered Services.

Family Out-of-Pocket Maximum means the dollar amount stated in the Schedule of Benefits for which an Employee and his or her covered eligible Dependents are responsible to pay for Covered Services during a Benefit Period. This maximum can be satisfied by a combination of services provided except Deductibles, Copayments, penalties, charges in excess of the Maximum Allowable Charge and non-Covered Charges.

FMLA means the Family and Medical Leave Act.

Freestanding Diagnostic Laboratory means an Other Provider that provides laboratory analysis for Other Providers.

Freestanding Dialysis Facility means an Other Provider that provides dialysis treatment, maintenance and training to patients on an Outpatient or home health care basis.

HIPAA means the Health Insurance Portability and Accountability Act.

HIPAA Late Enrollee means an Employee or eligible Dependent who did not apply, or for whom application was not made, for coverage within 30 days after such person first became eligible for coverage under this Plan. However, a person will *not* be considered a HIPAA Late Enrollee if:

- he or she already had other health care coverage at the time coverage under this Plan was previously offered; and
- he or she stated in writing at that time that such other coverage was the reason for declining coverage under this Plan; and
- such other coverage is exhausted (if the previous coverage was continuation coverage under COBRA) or the other coverage was terminated because he or she ceased to be eligible or employer contributions for such coverage ended; and
- he or she applies for coverage under this Plan within 30 days after the loss of the other coverage.

Dependents that become eligible for coverage under this Plan by reason of marriage, birth, adoption or placement for adoption after the Employee's Effective Date will not be considered HIPAA Late Enrollees, provided application is made by the Employee on behalf of such person(s) within 30 days of the marriage, birth, adoption or placement for adoption.

HIPAA Special Enrollee means an Eligible Employee or eligible Dependent who is permitted under HIPAA to enroll in the Plan if the Eligible Employee or eligible Dependent was covered under a group health plan or had health insurance at the time coverage was previously offered. Such coverage must have been COBRA coverage that was exhausted, or coverage by other health plans that ended due to loss of eligibility or employer contributions toward the coverage were terminated.

Home Health Care Agency means an Other Provider that is primarily engaged in providing home health care services.

Hospice means a public agency or private organization that provides services for a terminally ill patient in a home environment. It must be licensed by the state in which it is located, if licensing is required.

Hospital means a short-term, acute, general Hospital that:

- is a licensed institution;
- provided Inpatient services and is compensated by or on behalf of its patients;
- provides surgical and medical facilities primarily to diagnose, treat, and care for the injured and sick, except that a psychiatric Hospital will not be required to have surgical facilities;
- has a staff of Physicians licensed to practice medicine; and
- provides 24-hour nursing care by registered graduate nurses.

A facility which serves, other than incidentally, as a nursing home, Custodial Care home, health resort, rest home, rehabilitation facility, or place for the aged is not considered a Hospital.

Illness means a sickness or disease that requires treatment by a Physician or Other Professional Provider. It includes Pregnancy.

Injury means bodily Injury that requires treatment of a Physician or Other Professional Provider.

Inpatient means a Covered Person treated as a bed patient in a Hospital or Facility Other Provider and who incurs a room and board charge. For behavioral health benefits, Inpatient care can refer to treatment received at a Hospital, a behavioral health facility, or a behavioral health program.

Intensive Care Unit means a separate, clearly designated service area that is maintained within a Hospital solely for the care and treatment of patients who are critically ill and contains facilities for special nursing care not available in regular rooms and wards of the Hospital, special life saving equipment which is immediately available at all times, at least two beds for the accommodation of the critically ill, and at least one R.N. in continuous and constant attendance 24 hours a day.

Limiting Age (or **Dependent Child Limiting Age**) means the age after which a Child will no longer be considered an eligible Dependent.

Maximum Allowable Charge means the highest dollar amount of reimbursement for a particular Covered Service.

Maximum Lifetime Benefit means the total dollar amount of benefits available for Covered Services under the Plan for and during the Covered Person's lifetime. Such amount will be stated in the Schedule of Benefits. The Maximum Lifetime Benefit for the Covered Person will be subject to and reduced by amounts paid under the Plan in any and all Plan Years. The Maximum Lifetime Benefit will also be subject to and reduced by amounts paid under any other group health plan maintained by CHS or any of its affiliates.

Medical Care means professional services by a Physician or Other Professional Provider to treat an Illness, Injury, Pregnancy, or other medical condition.

Medical Director means a Physician designated to manage Quality Management, Pre-Admission and Pre-Treatment Certification, and Concurrent Review programs, or such Physician's authorized designee.

Medically Necessary means services or supplies that have been determined by the Plan to be of proven value for use in the general population. To be Medically Necessary a service or supply must:

- Have final approval from the appropriate government regulatory bodies,
- Have scientific evidence permitting conclusions concerning the effect of the service on health outcomes,
- Improve the net health outcome,
- Be as beneficial as any established alternative,
- Demonstrate the improvement outside the investigational setting, and
- Not be an Experimental or Investigational service or supply.

Mental and/or Nervous Disorder means a condition characterized by abnormal functioning of the mind or emotions and which psychological, intellectual, emotional, or behavioral disturbances are the dominant feature. Mental and nervous disorders include mental disorders, mental illnesses, psychiatric illnesses, mental conditions and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic, chemical or nonchemical origin and irrespective of cause, basis or inducement.

Mental and nervous disorders include alcohol, drug or chemical abuse or dependency, but do not include learning disabilities, attitudinal disorders, or disciplinary problems.

Mental Health Benefits means benefits provided for a Covered Charges for a Mental and/or Nervous Disorder.

Network Provider or Network Hospital means a Hospital, Physician or Other Professional Provider that has been designated by CHS to provide services to Covered Persons.

Out-of-Network Maximum Lifetime Benefit means the total dollar amount of benefits available for Covered Services provided by an Out-of-Network Provider or Out-of-Network Hospital under the Plan for and during the Covered Person's lifetime. Such amount, if any, will be stated in the Schedule of Benefits. The Out-of-Network Maximum Lifetime Benefit is a further limit on the Maximum Lifetime Benefit and does not provide any additional benefits above the Maximum Lifetime Benefit. The Out-of-Network Maximum Lifetime Benefit for the Covered Person will be subject to and reduced by amounts paid under the Plan in any and all Plan Years. The Out-of-Network Maximum Lifetime Benefit will also be subject to and reduced by amounts paid under any other group health plan maintained by CHS or any of its affiliates.

Out-of-Network Provider or Out-of-Network Hospital means a Hospital, Physician or Other Professional Provider that has not been designated by CHS to provide services to Covered Persons.

Out-of-Pocket Maximum means the dollar amount stated in the Schedule of Benefits for which an Employee is responsible to pay for Covered Services during a Benefit Period. This maximum can be satisfied by a combination of services provided except Deductibles, Copayments, penalties, charges in excess of the Maximum Allowable Charge and non-Covered Charges. See **Family Out-of-Pocket Maximum.**

Other Professional Providers or Professional Providers means and includes the following licensed providers, acting within the scope of their licenses:

- Doctor of Osteopathy (D.O.)
- Doctor of Dental Surgery (D.D.S.)
- Doctor of Dental Medicine (D.M.D.)
- Doctor of Optometry (O.D.)
- Doctor of Podiatric Medicine (D.P.M.)
- Doctor of Chiropractic (D.C.)
- Clinical Social Worker
- Independent Practitioners of Social Work
- Practical Nurse
- Vocational Nurse
- Nurse Midwife licensed as an R.N. and certified by the American College of Nurse Midwives
- Psychologist designated by law as a health service provider
- Psychological Examiner, supervised in accordance with state law
- Registered Physiotherapist
- Pharmacist (D. Pharm.)
- Occupational Therapist (for services to restore functioning of the hand following trauma)
- R.N., including an R.N. who is a nationally certified Nurse Practitioner, Nurse Anesthetist, or Clinical Specialist
- R.N. Anesthetist (R.N.A.)
- Psychologist (Ph.D.)

- Professional Physical Therapist
- Professional Counselor
- Audiologist
- Speech Language Pathologist
- Optometrist
- Physician's Assistant
- Registered Dietitian or Nutritionist (for nutritional counseling in connection with the treatment of diabetes only)

Other Providers mean and include:

- Suppliers of Durable Medical Equipment, appliance and prosthesis
- Suppliers of oxygen
- Certified ambulance service
- Hospice
- Pharmacy
- Freestanding Diagnostic Laboratory
- Home Health Care Agency

Outpatient means a Covered Person who receives services or supplies other than on an Inpatient basis.

Outpatient Care means treatment or care provided other than as an Inpatient Care.

Outpatient Surgery means Surgery performed in an Outpatient department of a Hospital, Physician's office, or Facility Other Provider.

Participating Providers means Network Providers.

Physician means a licensed physician legally entitled to practice medicine and perform Surgery. All Physicians must be licensed in the state in which Covered Services are rendered.

Plan Year means the plan year established by the plan administrator.

Post-service Claim means a claim for a Covered Service that is not a Pre-service Claim or claim for Urgent Care.

Pre-Admission Certification Program means those reporting and review requirements designed to encourage the delivery of required services in the most medically appropriate setting.

Pregnancy means childbirth and conditions associated with Pregnancy, including complications. While pregnancy of dependent children is not covered, complications of pregnancy of dependent children is covered.

Prescription Drug means the following when dispensed upon a written prescription:

- A drug or medicine which, under federal law, is required to bear the legend "Caution: Federal law prohibits dispensing without prescription."
- Injectable insulin.
- Hypodermic needles or syringes.

Pre-service Claim means any claim that requires approval of a Covered Service in advance of obtaining Medical Care as a condition of receipt of a Covered Service, in whole or in part.

Prior Authorization (Precertification) means those reporting and review requirements designed to encourage the delivery of medically appropriate services in the most medically appropriate setting before services are rendered. It will be the Covered Person's responsibility to advise the Physician of these requirements before he or she is admitted to any facility or receives certain Outpatient or other services. A Medical Director or designee may review services to determine whether they are:

- Medically Necessary;
- efficiently provided in the most appropriate setting;
- consistent with patterns of care found in an established managed care environment for treatment of a particular Illness, Injury or medical condition.

The Prior Authorization process includes, but is not limited to:

- admission review to determine whether an Inpatient admission or an admission not subject to Admission Review was Medically Necessary;
- length of stay assignment to indicate the number of Inpatient days usually Medically Necessary to treat the Covered Person's medical condition;
- continued stay review Concurrent Review to determine whether a continued Inpatient stay is Medically Necessary;
- discharge planning to assess the Covered Person's need for additional treatment after discharge from a Hospital.

Provider means a Hospital, Physician, Other Professional Provider, or Other Provider, licensed where required and rendering services within the scope of the applicable license.

Psychiatric Care means treatment of a Mental or Nervous Disorder. Psychiatric Care includes treatment for drug addiction or alcoholism.

Qualified Medical Child Support Order means a valid order, decree, or judgment by a court or governmental agency, including approval of a settlement agreement to pay a Child's medical expenses or provide medical insurance on behalf of the Child.

Qualifying Event means the following:

- Your death while an Employee.
- The termination of your employment (except for gross misconduct) or the reduction of hours of your employment.
- Your divorce or legal separation.
- Your becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare).
- Your Dependent Child ceasing to be a Dependent Child under the Plan.
- A bankruptcy proceeding commencing with respect to the employer from whose employment you retired at any time.

Residential Treatment Facility means a licensed Facility Other Provider, accredited by JCAHO, primarily engaged in providing detoxification and rehabilitation treatment for alcoholism and drug abuse.

Skilled Nursing Facility means a facility that provides convalescent and rehabilitative care on an Inpatient basis. Skilled nursing care must be provided by or under the supervision of a Physician. Neither (1) a facility that primarily provides minimal, custodial, ambulatory, or part-time care, nor (2) a

facility which treats mental illness, alcoholism, drug abuse or pulmonary tuberculosis is considered a skilled nursing facility.

Spinal Manipulation means care connected with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation where such care is for purposes of removing nerve interference and its effects, where interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column.

Spouse means only the Covered Person's current spouse under a legally-valid, licensed marriage between persons of the opposite sex including a spouse by common law marriage provided that the Eligible Employee provides proof satisfactory to the Plan Administrator to demonstrate the common law marriage. The covered Spouse must have his or her principal residence with the eligible employee.

Substance Abuse means a condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Substance Abuse Benefits mean benefits provided for a Covered Charges for Substance Abuse at a Substance Abuse Treatment Facility.

Substance Abuse Lifetime Maximum means the total dollar amount of benefits available for Covered Services under the Plan during the Covered Person's lifetime relating to Substance Abuse with such amount as stated in the Schedule of Benefits. The Substance Abuse Lifetime Maximum for the Covered Person will be subject to and reduced by amounts paid under the Plan in any and all Plan Years. The Substance Abuse Lifetime Maximum will also be subject to and reduced by amounts paid under any other group health plan maintained by CHS or any of its affiliates.

Substance Abuse Treatment Facility means a Facility Other Provider which provides a structured 24-hour per day program of Inpatient treatment and rehabilitation for drug dependency or alcoholism. A Substance Abuse Treatment Facility must be licensed to provide this type of care by the state in which it operates.

Surgery means the following:

- operative and cutting procedures, including use of special instruments;
- endoscopic examinations (the insertion of a tube to study internal organs), and other invasive procedures;
- treatment of broken and dislocated bones;
- usual and related pre- and post-operative care when billed as part of the charge for surgery; and
- other procedures that have been approved by the Plan Administrator.

Therapy Services mean and include the following for treatment of Illness or Injury:

- physical therapy - treatment to relieve pain, restore bodily function, and prevent disability following Illness, Injury, or loss of a body part;
- respiratory therapy - introduction of dry or moist gases into the lungs; and
- home infusion therapy - therapy in which fluid or medication is given intravenously. It includes total parenteral nutrition, enteral nutrition, hydration therapy, chemotherapy, aerosol therapy and intravenous drug administration;
- speech therapy – limited to coverage for disorders of articulation and swallowing, following an Acute Illness or birth defects.

- occupational therapy – treatment to improve the ability to perform tasks in daily living and working environments generally involving a loss of basic motor functions and/or reasoning abilities or to compensate for permanent loss of function.
- cardiac rehabilitation – comprehensive long term program aimed at improving health outcomes for patients with cardio vascular disease. The goal is to improve patient outcomes and reduce morbidity and mortality from cardio vascular disease.

Urgent Care means Medical Care or treatment that, if delayed or denied, could seriously jeopardize your life or health, or your ability to regain maximum function. Urgent Care is also Medical Care or treatment that, if delayed or denied, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the Medical Care or treatment.

Usual and Customary Charge. *Usual Charge* means the amount ordinarily charged by a Provider for any given service, and *Customary Charge* means a charge that falls within the range of the Usual Charges for any given service within the geographic area in which the service is rendered.

Vision Care Provider means a Physician or other vision care provider acceptable to the Plan Administrator for providing Covered Services with respect to vision benefits under the Plan and provided for under the policy maintained through VSP.

Weight Loss Surgery Lifetime Maximum means the total dollar amount of benefits available for Covered Services under the Plan during the Covered Person's lifetime relating to Surgery to reduce in any manner the weight of the Covered Person with such amount as stated in the Schedule of Benefits. The Weight Loss Surgery Lifetime Maximum for the Covered Person will be subject to and reduced by amounts paid under the Plan in any and all Plan Years. The Weight Loss Surgery Lifetime Maximum will also be subject to and reduced by amounts paid under any other group health plan maintained by CHS or any of its affiliates.

Year means calendar year.

Where capitalized terms are used in this Plan document and are not defined herein, the Plan Administrator reserves the right to apply the definitions set forth herein.

General Plan Provisions

Determinations
In carrying out their respective responsibilities under the Plan, the Plan Administrator and other fiduciaries will have the discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits according to the terms of the Plan. Any interpretation or determination made within their discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Rescission
If a false claim is submitted by a Covered Person, the Plan Administrator reserves the right to rescind and recover all benefits to the Covered Person.

Acts of Third Parties
Medical Care benefits are not payable to or for a person covered under the Plan when the Injury or Illness to the Covered Person occurs through the act or omission of another person. However, the Plan may elect to advance payment for Medical Care expenses incurred for an Injury or Illness in which a third party may be liable. For this to happen, the Covered Person must sign an agreement with the Plan to pay in full any sums advanced to cover such expenses from the judgment or settlement he or she receives which are identified as amounts paid for Medical Care expenses.

Amendment and Termination
The Plan Sponsor, acting through any duly-authorized officer of the Plan Sponsor, reserves the right to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan. No amendment will deprive any Covered Person or beneficiary of any benefit to which he or she is entitled under this Plan with respect to contributions previously made; and no amendment will provide for the use of funds or assets other than for the benefit of Covered Persons and their beneficiaries, except as may be specifically authorized by statute or regulation.

Construction
To the extent not preempted by ERISA, the Plan will be construed according to the laws of the State of Tennessee and all provisions hereof will be administered according to the laws of said state.

Coordination With Other Medical Care Benefits
Benefits provided under the Plan for Medical Care are subject to reduction in accordance with the provision headed “Coordination of Benefits” described in this Summary Plan Description.

Dependents Previously Covered As Employees
Benefits payable on behalf of a Dependent previously covered under the Plan as an Eligible Employee incurred during a period which began while the Dependent was covered as an Eligible Employee will not exceed the benefits that would have been payable during such period had the Dependent remained covered as an Eligible Employee.

Effect of Plan on Employment

The Plan will not be deemed to constitute a contract of employment between the Employer and any Eligible Employee or to be consideration or an inducement for the employment of any Eligible Employee. Nothing contained in this Plan will be deemed to give any Eligible Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Eligible Employee at any time regardless of the effect which such discharge will have upon him or her as a Covered Person of this Plan.

Filing of Information

Each Covered Person or other interested person will file with the third-party administrator (or the Plan Administrator if there is no third-party administrator) such pertinent information concerning the Covered Person as the third-party administrator may specify, including proof or continued proof of dependency or eligibility, and in such manner and form as the third-party administrator (or Plan Administrator) may specify or provide, and such person will not have rights or be entitled to any benefits, or further benefits hereunder, unless such information is filed by the Covered Person or on the Covered Person's behalf.

Headings and Captions

The headings and captions set forth in the Plan are provided for convenience only, will not be considered part of the Plan, and will not be employed in the construction of the Plan.

Medicare

The term "Medicare", as used herein, means the program established under Title XVIII of the Social Security Act (Federal Health Insurance for the Aged Act) as it is presently constituted or may hereafter be amended.

No Waiver or Estoppel

No term, condition or provision of the Plan will be deemed to have been waived, and there will be no estoppel against the enforcement of any provision of the Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver will be deemed a continuing waiver unless specifically stated therein, and each such waiver will operate only as to the specific term or condition waived and will not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Notices

Any notice, application, instruction, designation or other form of communication required to be given or submitted by any Covered Person or beneficiary will be in such form as is prescribed from time to time by the Plan Administrator and will be sent by first-class mail or delivered in person to the Plan Administrator. Any notice, statement, report or other communication from the Plan Administrator to any Covered Person will be deemed to have been duly delivered when given to such person or mailed first class to such person at the Covered Person's address last appearing on the records of the Plan Administrator or third-party administrator. Each person entitled to receive a payment under the Plan will file in accordance herewith the person's complete mailing address and any change thereof. If the Plan Administrator or third-party administrator will be in doubt as to whether payments are being received by the person entitled thereto, the Plan Administrator or third-party administrator may, by certified mail addressed to such person's address last known to the Plan Administrator or third-party administrator, notify such person that all future payments will be withheld until such person submits to the Plan

Administrator or third-party administrator the proper mailing address and such other information the Plan Administrator or third-party administrator may reasonably request.

Return of Overpayments

Payments made for charges must be returned to the Plan Administrator or third-party administrator if it is found that such charges were paid in error. The Plan Administrator or third-party administrator may deduct the amount of such overpayments from any subsequent benefits payable to the Covered Person or to other present or future amounts payable or to recover such amount by any other method that the Plan Administrator or third-party administrator will determine.

Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator or third-party administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine acceptability of any applicant or Covered Person in and/or benefits from the Plan. In so acting, the Plan Administrator or third-party administrator will be free from any liability that may arise with regard to such action. Any Covered Person claiming benefits under the Plan will furnish to the Plan Administrator or third-party administrator such information as may be necessary to implement this provision.

Severability

If any provision of the Plan will be held invalid or unenforceable, such invalidity or unenforceability will not affect any other provision, and the Plan will be construed and enforced as if such provision had not been included.

Assignment

No Covered Person shall have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute, or anticipate any benefit payment under the Plan to a third party, and such payment shall not be subject to any legal process to levy execution upon or attachment or garnishment proceedings against for the payment of any claims. Benefit payments under the Plan may not be assigned, transferred, or in any way made over to another party by a Covered Person. Nothing contained in this Plan shall be construed to make the Plan or the Plan Sponsor liable to any third party to whom a Covered Person may be liable for medical care, treatment, or services. If authorized in writing by a Covered Person, the Plan Administrator may pay a benefit directly to a provider of medical care, treatment, or services instead of the Covered Person as a convenience to the Covered Person; when this is done, all of the Plan's obligation to the Covered Person with respect to such benefit shall be discharged by such payment. However, the Plan reserves the right to not honor any assignment to any third party, including but not limited to, any provider. The foregoing does not preclude any assignment of payment to Medicaid to the extent required by law. The Plan will not honor claims for benefits brought by a third-party; such third-party shall not have standing to bring any such claim either independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

Administration Information

Plan Name
Community Health Systems Group Health Plan

Plan Sponsor and Plan Administrator
CHS/Community Health Systems, Inc.
P.O. Box 689020 (Zip 37068-9020)
4000 Meridian Boulevard
Franklin, TN 37067
(615) 465-7000

Covered Persons and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a sponsor of the Plan and, if the employer is a plan sponsor, the sponsor's address.

Plan Identification Number
Plan #501

Plan Administrator Identification Number
76-0137985

Type of Plan
Welfare benefit plan providing health care benefits.

Funding and Type of Administration
This Plan is self-administered in part and administered by an insurer in part. Covered Persons make contributions to the Plan on a pre-tax basis under Internal Revenue Code Section 125 for medical and dental care benefits. Covered Persons contribute at a fixed rate per payroll period toward the cost of the Plan through payroll deductions for their coverage and for dependent coverage, if any. The remainder of the cost of the Plan is paid by the Plan Sponsor.

Claims administration, Precertification, and case management for the benefits provided under the Plan is provided by various third-party service providers. Details may be obtained by writing to the Plan Administrator.

The vision care benefits provided under the Plan are fully-insured and administered through Vision Service Plan. Covered Persons contribute all of the premiums toward the cost of vision care through payroll deductions. All vision claims are processed by Vision Service Plan. The address of Vision Service Plan is:

Vision Services Plan
P.O. Box 2487
Columbus, Ohio 43216-2487

Certain other benefits under the Plan are fully-insured and administered through the insurer. With respect to all other benefits under the Plan, benefits are paid through the general assets of the Plan Sponsor.

Agent for Legal Process

CHS/Community Health Systems, Inc.
P.O. Box 689020 (Zip 37068-9020)
4000 Meridian Boulevard
Franklin, TN 37067
(615) 465-7000

Service of legal process may be made upon the Plan Administrator.

Plan Year and Plan Fiscal Year

January 1 through December 31

ERISA Information

As a Covered Person in the Plan, you are entitled to certain rights and protection under federal law, as stated in the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants will be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other locations, such as work sites, all Plan Documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is legally required to furnish each Covered Person with a copy of this summary annual report.
- Continue group health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for HIPAA Late Enrollees) after your enrollment date in your coverage.

Under federal law, a health plan or health insurance issuer generally may not restrict benefits for any hospital length of stay for a mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section, or require that a provider obtain preauthorization from the plan or the insurance issuer for prescribing stays within these time frames. Federal law generally does not prohibit the attending provider, after consulting with the mother, from discharging the mother or newborn earlier than the 48- or 96-hour periods.

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan are called fiduciaries. They have a duty to operate the Plan prudently and in the interest of you and other participants and beneficiaries.

No one, including your Employer, or any other provider, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights:

- For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical support order,

you may file suit in federal court. If the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

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

APPENDIX A

MEDICAL CARE SCHEDULE OF BENEFITS

[Insert your Summary of Benefits for Medical Care here including

any Summary of Benefits for Prescription Drugs]

APPENDIX B

HIPAA Privacy Standards

The following are required provisions under the Privacy Standards for Individually Identifiable Health Information (45 C.F.R. Parts 160 and 164, Subparts A and E) (the "Privacy Standards") as promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 by the U.S. Department of Health and Human Services regarding the protection of your private health information. The following provisions establish the circumstances under which the Plan may share your Protected Health Information with the Plan Sponsor and limit the uses and disclosures that the Plan Sponsor may make of your Protected Health Information.[1]

There are three circumstances under which the Plan may disclose information about you to the Plan Sponsor. First, the Plan may inform the Plan Sponsor whether you are participating in the Plan or are enrolled in or have disenrolled from a health insurance issuer or HMO offered by the Plan. Second, the Plan may disclose to the Plan Sponsor information that summarizes claims history, claims expenses, or types of claims without directly identifying you.[2] The Plan Sponsor must limit its use of such "summary health information" to obtaining quotes from insurers or modifying, amending, or terminating the Plan.[3] Third, the Plan may disclose your Protected Health Information to the Plan Sponsor for purposes relating to administration of the Plan, including payment of benefits or health care operations.

The Plan Sponsor shall certify to the Plan that the terms of the Plan have been amended to incorporate, and the Plan Sponsor has agreed to abide by the terms of, the following provisions.

The Plan Sponsor will use and disclose your Protected Health Information only as required or permitted by the Plan, as required by law, or as permitted under the Privacy Standards.

The Plan Sponsor has the following obligations with regard to your Protected Health Information received for purposes related to administering the Plan:

- If the Plan Sponsor discloses any of your Protected Health Information to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to agree to the same

[1] For purposes of the following provisions, "Protected Health Information" is individually identifiable information, transmitted or maintained in any form or medium, that is created or received by an entity covered by the Privacy Standards (for example, the Plan) or an employer and relates to your past, present or future physical or mental health or condition, the provision of health care to you or the past, present or future payment for the provision of health care to you. However, Protected Health Information does not include individually identifiable information held by the Plan Sponsor in its role as an employer.

[2] Summary health information excludes information that may directly identify you, such as your name, address and phone number, the day or month of dates directly related to you (such as your birth date), and your social security and health plan beneficiary numbers, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

[3] For purposes of these provisions, "summary health information" is information that may be individually identifiable information and that summarizes the claims history, claims expenses, or type claims experienced by you and for which the Plan Sponsor has provided benefits to you under the Plan.

restrictions and conditions that apply to the Plan Sponsor with respect to the disclosed Protected Health Information.

- The Plan Sponsor will not use or disclose your Protected Health Information for employment-related actions or decisions or in connection with any other benefits or benefit plan of the Plan Sponsor.

- The Plan Sponsor will promptly report to the Plan any use or disclosure of your Protected Health Information that is inconsistent with the uses or disclosures allowed under the Plan of which the Plan Sponsor becomes aware.

- The Plan Sponsor will allow you to inspect and copy any of your Protected Health Information that is in the Plan Sponsor's custody and control. However, your access to such Protected Health Information is subject to certain exceptions and restrictions under § 164.524 of the Privacy Standards. You may make a request for access to your Protected Health Information in writing to the Plan Sponsor. The Plan Sponsor may impose a reasonable, cost-based fee for providing a copy of your Protected Health Information.

  The Plan Sponsor may provide you with a summary of the Protected Health Information requested, provided that you agree in advance to such summary and to the fees imposed, if any, for such summary. The Plan Sponsor must provide you the requested access to your Protected Health Information or, if the Plan Sponsor denies your request, in whole or in part, the Plan Sponsor must provide you with a written denial, no later than 30 days after receipt of your request. If your request for access is for Protected Health Information that is not maintained or accessible to the Plan Sponsor on site, the Plan Sponsor must take action on your request by no later than 60 days from the receipt of your request.

  If the Plan Sponsor is unable to provide access or a written denial of your request within such time, the Plan Sponsor may extend the time to provide either by no more than 30 days, provided that the Plan Sponsor provides you with a written statement within the initial 30-day period of the reasons for the delay and the date by which the Plan Sponsor will either provide access or a written denial of your request. The Plan Sponsor may have only one extension of time for action on your request for access.

  If the Plan Sponsor denies in whole or in part your request for access, the Plan Sponsor must provide you a timely written denial that is in plain language and contains (1) the basis for the denial; (2) a statement of any review rights that you may have, including a description of how you may exercise such review rights; and (3) a description of how you may complain to the Plan Sponsor or the U.S. Department of Health and Human Services pursuant to the procedures set forth in the Privacy Standards. Such description will include the name, or title, and telephone number of the contact person or office of the Plan Sponsor designated to receive such complaints pursuant to the Privacy Standards. You may have the right to have the denial reviewed by a licensed health care professional who is designated by the Plan Sponsor and who did not participate in the original decision to deny. If you have the right to have the denial reviewed by a licensed health care professional, the Plan Sponsor must promptly refer your request for review to such designated reviewing official, who must determine, within a reasonable period of time, whether to deny the access requested pursuant to the Privacy Standards. The Plan Sponsor must promptly provide you written notice of the determination of the designated reviewing official and take such other action as may be required to carry out the designated reviewing official's determination.

- The Plan Sponsor will make available for amendment and incorporate any amendments to any portion of your Protected Health Information to the extent permitted or required under § 164.526 of the Privacy Standards. The Plan Sponsor may deny your request for amendment under certain circumstances. You may request an amendment of your Protected Health Information in writing. The Plan Sponsor must act on your request no later than 60 days after receipt of your request. If the Plan Sponsor is unable to act within such time, the Plan Sponsor may extend the time for such action by no more than 30 days, provided the Plan Sponsor provides you within the original 60-day period with a written statement of the reasons for the delay and the date by which the Plan Sponsor will complete its action on your request. The Plan Sponsor may have only one such extension of time for action on a request for an amendment.

  If the Plan Sponsor accepts the requested amendment, in whole or in part, the Plan Sponsor must make the appropriate amendment to your Protected Health Information that is the subject of your request for amendment by, at a minimum, identifying the records that are affected by the amendment and appending or otherwise providing a link to the amendment. The Plan Sponsor must also provide you with timely notice that the amendment is accepted and obtain your identification of, and agreement to have the Plan notify, the relevant persons with whom the amendment needs to be shared. Such relevant persons include persons identified by you as having received Protected Health Information about you and needing the amendment, and persons that the Plan Sponsor knows have the Protected Health Information that is the subject of the amendment and who may have relied, or could foreseeably rely, on such information to your detriment.

  If the Plan Sponsor denies your requested amendment, in whole or in part, the Plan Sponsor must provide you with a timely written denial. Such denial must use plain language and contain (1) the basis for the denial; (2) your right to submit a written statement disagreeing with the denial and how you may file such a statement; (3) a statement that, if you do not submit a statement of disagreement, you may request that the Plan Sponsor provide your request for amendment and the denial with any future disclosures of the Protected Health Information that is the subject of the amendment; and (4) a description of how you may complain to the Plan Sponsor or to the U.S. Department of Health and Human Services pursuant to the Privacy Standards. Such description will include the name, or title, and telephone number of the contact person or office of the Plan Sponsor designated to receive such complaints pursuant to the Privacy Standards. The Plan Sponsor must permit you to submit a written statement disagreeing with the denial of all or part of a requested amendment and the basis of such disagreement. The Plan Sponsor may prepare a written rebuttal to your statement of disagreement. Whenever such a rebuttal is prepared, the Plan Sponsor must provide a copy to you.

- The Plan Sponsor will maintain an accounting of certain kinds of disclosures of your Protected Health Information as required under § 164.528 of the Privacy Standards. Such accounting must be made for certain disclosures of Protected Health Information made by the Plan Sponsor during the six years prior to the date on which you request the accounting. The Plan Sponsor does not have to maintain an accounting of disclosures made for certain purposes related to the administration of the Plan, including payment of benefits or health care operations, and certain other disclosures. You may request in writing an accounting of disclosures by the Plan Sponsor of your Protected Health Information. The Plan Sponsor must act on your request no later than 60 days after receipt of your request by either providing you with the accounting requested or by extending the time to provide the accounting by no more than 30 days. The Plan Sponsor may extend the time to act upon your request provided that the Plan Sponsor provides you with a written statement of the reasons for the delay and the date by which the Plan Sponsor will provide the accounting. The Plan Sponsor must provide the first accounting to you in any 12-month period without charge. The Plan Sponsor may impose a reasonable, cost-based fee for each subsequent request for an accounting by you within

the 12-month period, provided the Plan Sponsor informs you in advance of the fee and provides you with an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

- The Plan Sponsor will make its internal practices, books, and records relating to its use and disclosure of your Protected Health Information available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards.

- The Plan Sponsor will, if feasible, return or destroy all of your Protected Health Information that the Plan Sponsor still maintains in any form and retain no copies of your Protected Health Information received from the Plan when the Plan Sponsor no longer needs your Protected Health Information for the purpose for which disclosure was made. If it is not feasible for the Plan Sponsor to return or destroy your Protected Health Information, the Plan Sponsor will limit the use or disclosure of any Protected Health Information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

- The Plan Sponsor will provide for an adequate separation between the Plan and the Plan Sponsor. The following classes of Employees or persons under the control of the Plan Sponsor may be given access to your Protected Health Information for purposes consistent with the terms of the Plan:

  (1) Members of the Plan's Claims Review Committee;

  (2) Any member of the Community Health Systems Human Resources Department for benefits.

  This list includes every class of Employees or other persons under the control of the Plan Sponsor who may receive your Protected Health Information in the ordinary course of business related to the administration of the Plan, including payment of benefits, health care operations, or other matters pertaining to the Plan. Such Employees' access to and use of your Protected Health Information is restricted to administrative functions that the Plan Sponsor performs for the Plan. For purposes of these provisions, administrative functions include, for example, the activities undertaken to obtain premiums or to provide benefits under the Plan and quality assurance, planning and development, and general administration. Administrative functions do not include any employment-related functions or functions in connection with any other benefit or benefit plans maintained by the Plan Sponsor.

The Plan Sponsor will provide an effective mechanism for resolving any issues of non-compliance by its Employees or other persons under the control of the Plan Sponsor with the provisions of the Plan pertaining to Protected Health Information. If any Employees or other persons under the control of the Plan Sponsor use or disclose your Protected Health Information in violation of the terms of the Plan, they will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to you.

APPENDIX C

HIPAA Security Standards

The following are required provisions under the Security Standards for the Protection of Electronic Protected Health Information (45 C.F.R. Parts 160 and 164, Subparts A and C) as promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 by the U.S. Department of Health and Human Services regarding the security of your private health information.

For purposes of the following provisions, the following definitions apply:

- "Administrative Safeguards" are administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of Security Measures to protect Electronic Protected Health Information and to manage the conduct of members of the Plan Sponsor's workforce who are involved in the administration of the Plan in relation to the protection of Electronic Protected Health Information.

- "Availability" means the property that data or information is accessible and useable upon demand by a person authorized to access and use such data or information.

- "Confidentiality" means the property that data or information is not made available or disclosed to unauthorized persons or processes.

- "Integrity" means the property that data or information have not been altered or destroyed in an unauthorized manner.

- "Physical Safeguards" are physical measures, policies, and procedures to protect the Plan's electronic information systems and related buildings and equipment from natural and environmental hazards, and unauthorized intrusion.

- "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an Information System. For purposes of this definition, "Information System" means an interconnected set of information resources under the same direct management control that shares common functionality. A "System" normally includes hardware, software, information, data, applications, communications, and people.

- "Security Measures" encompass all of the Administrative, Physical, and Technical Safeguards in an Information System.

- "Technical Safeguards" means the technology and the policy and procedures for its use that protect Electronic Protected Health Information and control access to it.

Effective April 20, 2005, the Plan Sponsor will reasonably and appropriately safeguard Electronic Protected Health Information[1] created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan. The Plan Sponsor will—

[1] For purposes of the following provisions, "Electronic Protected Health Information" means Protected Health Information that is transmitted by or maintained in (1) electronic storage media including memory devices in *(footnote continued on following page …)*

(i) Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the Electronic Protected Health Information that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

(ii) Implement Administrative, Physical, and Technical Safeguards to ensure that only the following classes of employees or other persons under the control of the Plan Sponsor may have access to your Electronic Protected Health Information in the ordinary course of business related to administration of the Plan:

(1) Members of the Plan's Claims Review Committee;

(2) Any member of the Community Health Systems Human Resources Department for benefits.

The Plan Sponsor will take reasonable steps to ensure that such Employees' access to and use of your Electronic Protected Health Information is restricted to administrative functions that the Plan Sponsor performs for the Plan;

(iii) Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic Protected Health Information agrees to implement reasonable and appropriate Security Measures to protect such Electronic Protected Health Information; and

(iv) Report to the Plan any Security Incident of which the Plan Sponsor becomes aware.

(… footnote continued from previous page)

computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (2) transmission media used to exchange information already in electronic storage media. "Transmission media" include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

APPENDIX D

PRIVACY NOTICE OF THE CHS/COMMUNITY HEALTH SYSTEMS, INC.

GROUP HEALTH PLAN

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.

This notice gives you information required by law about the duties and privacy practices of the CHS/Community Health Systems, Inc. Group Health Plan (the "Plan") to protect the privacy of your medical information. The Plan provides health benefits to you as described in your summary plan description. The Plan is sponsored by CHS/Community Health Systems, Inc. (the "Plan Sponsor"). The Plan receives and maintains your medical information in the course of providing these health benefits to you. The Plan is required by law to maintain the privacy of your medical information and to provide you with this notice about the Plan's duties and privacy practices with respect to your medical information.

The Plan is required to follow the terms of this notice until it is replaced. The Plan reserves the right to change the terms of this notice at any time and to make the terms of the revised notice effective for all of your medical information which the Plan maintains. If the Plan makes changes to this notice, the Plan will revise it and send a new notice to all subscribers covered by the Plan at that time.

How the Plan May Use or Disclose Your Medical Information Without Your Written Permission

Generally, the Plan may not use or disclose your medical information without your written authorization. However, in certain circumstances, the Plan is permitted to use your medical information without authorization. The following categories describe different ways that the Plan may use and disclose your medical information without your written authorization. Included in each category of uses or disclosures are some examples. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information without your written authorization should fall within one of these categories:

Treatment, Payment or Health Care Operations

- *Health Care Providers' Treatment Purposes*. For example, the Plan may disclose your medical information to your doctor, at the doctor's request, for your treatment by him.

- *Payment*. For example, the Plan may use or disclose your medical information to pay claims for covered health care services or to provide eligibility information to your doctor when you receive treatment.

- *Health Care Operations*. For example, the Plan may use or disclose your medical information (i) to conduct quality assessment and improvement activities, (ii) for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of a contract of health insurance, and (iii) to manage, plan or develop the Plan's business.

As Otherwise Allowed By Law

The following categories describe different ways that the Plan may use and disclose your medical information for other than treatment, payment or health care operations without your written authorization. Some of the examples listed in these categories may require your permission, though your

permission need not be given in writing. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information for other than treatment, payment or health care operations without your written authorization should fall within one of these categories.

- *Health Services*. The Plan may use your medical information to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- *As Required by Law*. For example, in certain circumstances the Plan must allow the U.S. Department of Health and Human Services to audit Plan records. The Plan may also disclose your medical information as required by workers' compensation or other similar laws.

- *To Business Associates*. The Plan hires business associates to help it provide benefits to you. These business associates also receive and maintain your medical information in the course of assisting the Plan. Each business associate of the Plan must agree in writing to ensure the continuing confidentiality and security of your medical information.

- *To Plan Sponsor*. The Plan may disclose to the Plan Sponsor, in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. The Plan may also disclose to the Plan Sponsor the fact that you are enrolled in, or disenrolled from, the Plan. The Plan may disclose your medical information to the Plan Sponsor for Plan administrative functions that the Plan Sponsor provides to the Plan if the Plan Sponsor agrees in writing to ensure the continuing confidentiality and security of your medical information. The Plan Sponsor must also agree not to use or disclose your medical information for employment-related activities or for any other benefit or benefit plans of the Plan Sponsor.

- *For Involvement in Payment for Your Care.* Consistent with applicable law, the Plan may use or disclose information to family members or others whom you have involved in your care or the payment for your care.

- *Marketing.* The Plan may communicate with you face-to-face regarding goods and services that may be of interest to you and may provide you with promotional gifts of nominal value.

- *Fundraising.* The Plan may contact you as part of a fund-raising effort.

The Plan may also use and disclose your medical information as follows:

- In the course of a legal proceeding, in response to an order of a court or administrative tribunal or in response to a subpoena, discovery request or other lawful process.
- Consistent with applicable law, to law enforcement officials for limited law enforcement purposes.
- To your personal representatives appointed by you or designated by applicable law.
- For research purposes in limited circumstances.
- To funeral directors, coroners and medical examiners consistent with applicable law to carry out their duties.
- To an organ procurement organization in limited circumstances.
- Consistent with applicable law, to a government authority, including a social service or protective services agency, if the Plan reasonably believes you to be a victim of abuse, neglect, or domestic violence.
- Consistent with applicable law, to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- To a governmental agency authorized to oversee the health care system or government programs.
- To federal officials for lawful intelligence, counterintelligence and other national security purposes.
- Consistent with applicable law, to public health or legal authorities charged with preventing or controlling disease, Injury, or disability.
- To appropriate military authorities, if you are a member of the armed forces.

- If you are an inmate in a correctional institution and if the correctional institution or law enforcement authority makes certain representations, the Plan may disclose your health information to a correctional institution or law enforcement official in certain circumstances.
- When authorized by and to the extent necessary to comply with workers' compensation or similar programs established by law.

Uses and Disclosures with Your Written Permission

The Plan will not use or disclose your medical information for any other purposes unless you give the Plan your written authorization to do so. If you give the Plan written authorization to use or disclose your medical information for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your medical information the Plan maintains, unless the Plan has taken action in reliance on your authorization.

Your Rights

You may make a written request to the Plan to do one or more of the following concerning your medical information that the Plan maintains:

- To put additional restrictions on uses and disclosures of your medical information for treatment, payment, or health care operations or on certain disclosures to persons, such as family members involved with your care or the payment for your care. However, the Plan is not required to agree to these requests.
- To communicate with you in confidence about your medical information by a different means or at a different location than the Plan is currently doing. The Plan does not have to agree to your request unless such confidential communications are necessary to avoid endangering you and your request continues to allow the Plan to collect premiums and pay claims. Your request must specify the alternative means or location to communicate with you in confidence. Even though you requested that we communicate with you in confidence, the Plan may give subscribers cost information.
- To see and get copies of your medical information. In limited cases, the Plan does not have to agree to your request.
- To correct your medical information. In some cases, the Plan does not have to agree to your request.
- To receive a list of disclosures of your medical information that the Plan and its business associates made for certain purposes for the last 6 years (but not for disclosures before April 14, 2003).
- To send you a paper copy of this notice, even if you agreed to receive this notice by e-mail or on the internet.

If you want to exercise any of these rights described in this notice, please contact the Contact Office (below). The Plan will give you the necessary information and forms for you to complete and return to the Contact Office. In some cases, the Plan may charge you a reasonable, cost-based fee to carry out your request.

Complaints

If you believe your privacy rights have been violated by the Plan, you have the right to complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with the Plan at our Contact Office (below). We will not retaliate against you if you choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

Contact Office

To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact the CHS/Community Health Systems, Inc. HIPAA Privacy Officer at (615) 465-_____.

APPENDIX E

ELIGIBILITY AND ENROLLMENT

Eligibility Waiting Period

The Eligibility Waiting Period is:

(a) one (1) full calendar month for employees of all facilities other than Watsonville Community Hospital; or

(b) 90 days for employees of Watsonville Community Hospital.

However, the Eligibility Waiting Period may be waived by CHS in connection with an acquisition of a Hospital facility or other entity.

Leave Periods

For the purposes of eligibility:

(a) For employees of all facilities other than Watsonville Community Hospital, the permitted leave period and temporary layoff period cannot exceed the length of the federal Family and Medical Leave Act, or, if longer, the state-mandated family leave applicable to the Participant's primary place of employment.

(b) For employees of Watsonville Community Hospital, the permitted leave period is such leave period as provided for in the collective bargaining agreement with respect to leaves of absence and/or applicable family and medical leave laws (FMLA/CFRA).

Scheduled Work Hours

You must be regularly scheduled to work on the following basis:

(a) 20 hours per week for employees of facilities other than Watsonville Community Hospital; or

(b) 40 hours bi-weekly for employees of Watsonville Community Hospital.

Coverage Period if Not Working

Coverage may continue for up to the number of days specified below if you are on leave as provided for under the Plan:

(a) All facilities other than Watsonville Community Hospital – the greater of FMLA/state mandated protected leave or 90 days.

(b) Watsonville Community Hospital – during FMLA/CFRA and while employee is maintaining paid status during absence.