

**OLYMPIA COMMUNITY UNIT SCHOOL
DISTRICT 16
HEALTH BENEFIT PLAN**

OLYMPIA COMMUNITY UNIT SCHOOL DISTRICT 16 HEALTH BENEFIT PLAN

HEALTH BENEFIT PLAN

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INTRODUCTION

The Olympia Community Unit School District 16 Health Benefit Plan (“Plan”) is a self-funded health benefit plan established to provide Hospital and medical benefits for Employees of Olympia Community Unit School District 16 (“Employer”). This Plan represents the efforts of the Employer to provide its Employees and their Dependents with the best possible health benefits at an affordable cost.

This booklet provides you with a description of all benefit provisions in the Plan, your rights under federal law, how you establish and/or lose eligibility and how to appeal if a Claim is not handled satisfactorily. Thus, we are asking you to review this booklet and familiarize yourself with the rules and requirements and the benefits to which you may be entitled.

In reviewing this booklet, you will note that a number of terms and phrases are capitalized. This usually means that there is a definition of these terms contained in the “Definitions” section of the Plan. It will be helpful to refer to these definitions as you review your benefits.

If you would like to contact the Contract Administrator, you may do so between 8 a.m. and 5 p.m., Central Time, Monday through Friday, using the telephone numbers listed on the General Information page. However, any information that you obtain over the phone in this manner concerning your rights and benefits may not be relied upon as a guarantee of your rights, or that benefits will be paid in that manner. The availability of benefits is determined solely on the basis of the terms of the Plan as contained in this booklet. A final determination of your rights and benefits cannot be made until all necessary documentation and information is submitted to the Contract Administrator and your Claim is fully adjudicated.

GENERAL INFORMATION

The following information, together with the information contained in this booklet, form the master plan and SUMMARY PLAN DESCRIPTION of the Plan.

1. Name of Plan:

Olympia Community Unit School District 16 Health Benefit Plan
2. Name and Address of Plan Sponsor and Plan Administrator:

Olympia Community Unit School District 16
903 E. 800 North Road
Stanford, IL 61774
(309) 379-6011
3. Type of Plan:

Welfare benefit plan providing medical, prescription drug, dental and vision benefits
4. Funding:

The Plan is self-funded by Olympia Community Unit School District 16.
5. Contract Administrator:

HCH Administration, Inc.
P.O. Box 1986
Peoria, IL 61656-1986
(309) 673-7330
1-800-322-1516
1-800-447-3227 (customer service)
e-mail: customerservice@hchadmin.com
6. Utilization Review Administrator:

HCH Administration, Inc.
24-hour Pre-Certification Number: 1-800-851-4630
7. COBRA Notice Coordinator:

HCH Administration, Inc.
COBRA Unit
P.O. Box 1986
Peoria, IL 61656-1986
(309) 673-7330
(800) 322-1516
(800) 447-3227 (customer service)
email: customerservice@hchadmin.com

8. Agent for Service of Legal Process:

Olympia Community Unit School District 16
903 E. 800 North Road
Stanford, IL 61774

9. Sources of Contributions to the Plan:

The cost of providing benefits under the Plan is shared by the Employer and Employees. A schedule will be distributed periodically, setting forth the contributions required of the Employees participating in the Plan.

10. Fiscal Year of the Plan: September 1 through August 31

11. Effective Date of the Plan: September 1, 2005

12. Effective Date of Plan Restatement: September 1, 2010

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

| DEDUCTIBLE, PER CALENDAR YEAR | | |
|--|---|---|
| Employee | | \$500 |
| Employee + 1 | | \$1,000 |
| Per Family Unit | | \$1,500 |
| MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR | PPO Provider | Non-PPO Provider |
| Employee (including deductible) | \$1,000 | \$2,000 |
| Employee + 1 (including deductible) | \$2,000 | \$6,000 |
| Per Family Unit (including deductible) | \$3,000 | \$6,000 |
| <ul style="list-style-type: none"> • The Preferred Provider and Non-Preferred Provider Out-of-Pocket Maximums are calculated on a separate basis. • Unless otherwise noted, the Plan will pay the designated percentage of covered charges after the calendar year deductible is met until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the calendar year. • The following do not apply to your out-of-pocket limit: <ul style="list-style-type: none"> ○ Copayments ○ Outpatient Mental Illness/Substance Abuse services ○ Plan Exclusions ○ Vision Benefits ○ Dental Benefits ○ Utilization Review Penalty | | |
| LIFETIME MAXIMUM | | \$2,000,000 |
| Covered charges for routine mammograms (including diagnostic ultrasounds) do not apply to the lifetime maximum when received from a Preferred Provider. | | |
| COVERED SERVICES | PPO Provider | Non-PPO Provider |
| Well-Adult Care (age 16+) | 100% up to \$400 maximum per calendar year (Deductible waived) | |
| Well-Child Care (birth to age 16) (Immunizations excluded) | 100% up to \$200 maximum per calendar year (Deductible waived) | |
| Hospital Services | | |
| Room and Board (semi-private) | 90% | 70% |
| ICU or CCU | 90% | 70% |
| Other Inpatient | 90% | 70% |
| Outpatient Surgery & Diagnostic | 90% | 70% |
| Outpatient Pre-Admission Testing | 90% | 70% |
| Outpatient Emergency Room | \$100 Copayment, then 90% (Deductible waived) | \$100 Copayment, then 70% (Deductible waived) |
| Hospital Satellite Urgent Care Clinic | \$20 Copayment, then 100% (Deductible waived) | 70% |
| Inpatient Rehabilitation Facility | 90% | 70% |
| Skilled Nursing Facility ¹ | 90% | 70% |
| Physician Services | | |
| Inpatient visits | 90% | 70% |
| Office visits (exams only) | \$20 Copayment, then 100% (Deductible waived) | 70% |

| | PPO Provider | Non-PPO Provider |
|--|---|---|
| Labs, X-rays | 90% | 70% |
| Office Surgery | 90% | 70% |
| Other Surgery | 90% | 70% |
| Second Surgical Opinions | 90% | 70% |
| Colonoscopy (preventive as recommended by the ACS guidelines) | 100% (Deductible waived) | 70% |
| Routine Hearing Exam (age 19+) | \$20 Copayment, then 100% (Deductible waived) | Not covered |
| Routine Mammograms | 100% (Deductible waived) | 70% |
| Home Health Care ² | 90% | 70% |
| Hospice Care | 90% | 70% |
| Oral Surgery | 90% | 70% |
| Private Duty Nursing ³ | 90% | 70% |
| TMJ | \$1,000 maximum per calendar year | |
| Ambulance Service | 80% | 80% |
| Occupational Therapy ⁴ | 90% | 70% |
| Speech Therapy ⁴ | 90% | 70% |
| Physical Therapy ⁴ | 90% | 70% |
| Respiratory Therapy ⁴ | 90% | 70% |
| Chiropractic Treatment | 80% \$250 maximum per calendar year | |
| Durable Medical Equipment | 90% | 70% |
| Prosthetics | 90% | 70% |
| Medical Supplies | 90% | 70% |
| Maternity | Same as any Sickness | |
| Birth Center | 90% | 70% |
| Mental Illness ⁵ | | |
| Office visits and Outpatient Treatment | 50% Maximum 30 days/visits per calendar year | |
| Inpatient treatment | 90% Maximum 30 days/visits per calendar year | 70% Maximum 30 days/visits per calendar year |
| Substance Abuse ⁵ | | |
| Office visits and Outpatient Treatment | 50% Maximum 30 days/visits per calendar year | |
| Inpatient treatment | 90% Maximum 30 days/visits per calendar year | 70% Maximum 30 days/visits per calendar year |
| Substance Abuse Lifetime Maximum | \$25,000 | |
| Organ Transplants | 90% | 70% |
| Gastric Bypass Surgery | \$5,000 Copayment, then 90% (Deductible waived) | \$5,000 Copayment, then 70% (Deductible waived) |
| Lap Band Surgery | \$2,500 Copayment, then 90% (Deductible waived) | \$2,500 Copayment, then 70% (Deductible waived) |

| | PPO Provider | Non-PPO Provider |
|---|---------------------|-------------------------|
| Autism Spectrum Disorder | 90% | 70% |
| Maximum benefit is the annual limit required by law. To determine the maximum benefit available, call the Customer Service department at the number listed on the back of your Identification Card. | | |
| All Other Covered Services⁶ | 90% | 70% |
| Prescription Drug Program Benefits | | |
| Pharmacy (30-day supply) | | |
| Generic Drug | | \$10 Copayment |
| Formulary Drug | | \$20 Copayment |
| Non-Formulary Drug | | \$40 Copayment |
| Mail-Order (90-day supply) | | |
| Generic Drug | | \$15 Copayment |
| Brand-Name Drug | | \$30 Copayment |
| Non-Formulary Drug | | \$60 Copayment |
| Utilization Review Penalty | | \$1,000 |

¹ Skilled Nursing has 120 days per Sickness or Injury maximum.

² Home Health Care has 100 days/visits maximum per calendar year.

³ Private Duty Nursing has a \$5,000 maximum per calendar year.

⁴ Therapy has a \$5,000 combined maximum per calendar year.

⁵ Mental Illness/Substance Abuse has 30 days/visits combined maximum per calendar year. This includes inpatient and outpatient services.

⁶ Except with respect to dental and vision benefits described in the Dental and Vision Benefits section.

UTILIZATION REVIEW

The Utilization Review Administrator must be notified prior to any of the following:

- All inpatient surgeries/procedures and admissions
- Acute hospitalization
- Acute rehabilitation
- Hospice
- All potential organ transplants
- Bariatric Surgery
- Emergency admissions (within 48 hours of admission)

Failure to notify the Utilization Administrator or failure to follow the instructions of the Utilization Review Administrator following notification will result in a penalty in the form of a reduction in benefits otherwise computed. The reduction shall be the lesser of (i) actual benefits available under the Plan, or (ii) \$1,000.

Pre-determination for Medical Necessity is recommended prior to receiving the following outpatient procedures/services:

Surgical

- Blepharoplasty
- Mammoplasty
- Mandibular Reconstruction, Osteotomy/Jaw Surgery
- Maxillary Osteotomy, Orthognathic Surgery
- Rhinoplasty
- Septoplasty
- Uvulopalatopharyngoplasty/Uvulectomy (UPPP)
- Varicose veins
- Excision of Benign skin lesion greater than \$500
- Tonsillectomy for adults 18 and over

Diagnostic

- All ongoing injectable medication treatment plans greater than \$100 (e.g., growth hormones, Epogen®, Neupogen®, BetaSeron®, Lupron®)
- PET scans
- Infusion IV/intravenous therapy
- Pulmonary rehabilitation
- Durable Medical Equipment greater than \$1,000 (e.g., oxygen equipment, CPAP concentrators)
- Hospice
- Home Health Care and Services

EXHIBIT A
PREFERRED PROVIDER LISTING

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care Providers, which are called Preferred Providers. Because these Preferred Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Covered Person or Covered Dependent uses a Preferred Provider, he/she will receive a higher payment from the Plan than when a Non-Preferred Provider is used. It is the Covered Person's or Covered Dependent's choice as to which Provider to use. See the Schedule of Benefits for a description of Preferred Provider Benefits and Non-Preferred Provider Benefits.

Health Alliance is the Preferred Provider network for this Plan. A listing of the Preferred Providers in the Health Alliance network is available by calling the Customer Service Department listed on your Plan ID Card or by visiting the HCH website at www.hchadmin.com.

DENTAL BENEFITS

| | |
|---|-------------------------|
| Benefit | |
| Preventive/Basic Services | 80% (Deductible waived) |
| Major Services | 50% |
| Orthodontic Services | 50% |
| Maximum Annual Benefit (excluding Orthodontic Services) | \$1,500 |
| Maximum Lifetime Benefit for Orthodontic Services (ages 6 – 19) | \$2,500 |

VISION BENEFITS

| | |
|------------------------------|--|
| Calendar Year Maximum | \$225 (Exams, frames, lenses and contact lenses combined) |
|------------------------------|--|

NOTICES

Childbirth

Group health plans generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a Cesarean section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods. However, this provision generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours, as applicable). This determination must be made in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics. Upon evaluation and the recommendation of a Physician, a post-discharge Physician office visit or in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge is also covered.

Breast Reconstruction

This Plan is required to provide the following benefits for elective breast reconstruction in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications in all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient. Such coverage is subject to all other Plan terms and limitations.

In the absence of malignancy, coverage is limited to reconstructive services received within two (2) years after the date of the mastectomy.

Notification

It is the Covered Person's or Covered Dependent's responsibility to notify the Employer or Plan Administrator within fifteen (15) days of any event which would cause such person or a family member to (i) gain or lose eligibility for coverage under the Plan, (ii) become eligible for or entitled to any Plan benefit, or (iii) lose

eligibility for or entitlement to any Plan benefit unless the Plan elsewhere specifically provides for a longer notice provision. The foregoing includes, but is not limited to, the following:

- Notifying the Plan Administrator of an address change within fifteen (15) days of such change;
- Notifying the Plan Administrator of a name change within fifteen (15) days of such change.

This Schedule is a summary of Plan benefits. Please read the remainder of this booklet carefully for a detailed explanation of Plan benefits and limitations.

EMPLOYEE ELIGIBILITY

Eligibility Requirements

Each Employee and that Employee's Eligible Dependents shall be eligible to participate in the Plan on the first Eligibility Date following attainment of status as a Full-Time Employee (thirty or more hours per week). An Employee must make written application for coverage and sign a payroll deduction order, if necessary, prior to coverage becoming effective.

If an Employee applies for coverage more than thirty (30) days after otherwise satisfying the above requirements, the Employee must submit, at his/her own expense, evidence of his/her good health which is satisfactory to the Employer and Contract Administrator. The Employee's Eligibility Date will be the first day of the month following the date of approval by the Employer and Contract Administrator of the evidence of his/her good health.

Eligibility Date

An Employee shall be eligible for coverage under the Plan on the first day of the month coincident with or next following the month during which he or she satisfies the Eligibility Requirements outlined above, provided he or she is properly enrolled in the Plan within thirty (30) days of that date and is in Active Service on that date. Otherwise, coverage under the Plan shall be deferred until he/she returns to Active Service.

Annual Enrollment

Every August, the annual open enrollment period, covered Employees will be able to change some of their benefit decisions based on which benefits and coverages are right for them. This includes the removal of Dependents from coverage or the addition of eligible Dependents without the application of proof of good health.

Benefit choices made during the open enrollment period will become effective September 1. To the extent previously satisfied coverage Waiting Periods and Pre-Existing Conditions Limits will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

A Covered Person who fails to make an election during open enrollment will automatically retain his or her present coverages.

Covered Employees will receive detailed information regarding open enrollment from their Employer.

Selection of Coverage

Covered Persons may select, at such times and in such manner as the Employer may require, coverage under the Medical Benefits Section and the Dental and Vision Benefits Section only in accordance with the following:

1. A Covered Person who selects Medical Benefits coverage is automatically provided Dental and Vision Benefits coverage.
2. A Covered Person who selects Medical Benefits coverage for his/her Eligible Dependents may also select Dental and Vision Benefits for such dependents.

3. A Covered Person who selects only Dental and Vision Benefits for himself/herself may also select Dental and Vision Benefits coverage for his/her Eligible Dependents.
4. A Covered Person who selects Medical Benefits for himself/herself may select Dental and Vision Benefits for his or her Eligible Dependents.
5. A Covered Person who selects the Supplemental Plan for himself/herself may select Dental and Vision Benefits for his or her Eligible Dependents.

DEPENDENT ELIGIBILITY

Eligibility for Dependent Coverage

A Covered Person may obtain benefits for his/her Eligible Dependents under the Plan on:

1. The date the Covered Person is eligible for coverage under the Plan, if on that date he/she has such Eligible Dependents; or
2. The date the Covered Person gains an Eligible Dependent, if on that date he/she is covered by the Plan.

In addition, a Covered Person may obtain benefits for his or her Eligible Dependent Child(ren) under the Plan during the thirty (30) day period prior to the beginning of a Plan Year.

An Employee must make written application for coverage and sign a payroll deduction order, if necessary, prior to coverage for an Eligible Dependent becoming effective.

In the event two parents are both eligible to be covered by the Plan as Covered Persons, only one parent will be eligible to cover any Eligible Dependent children they might have.

Eligibility Date of Dependent Coverage

1. The Eligibility Date of coverage for each Eligible Dependent will be the later of (i) the date on which the Covered Person who is the source of a dependent's eligibility becomes eligible for dependent coverage or (ii) the date the dependent becomes an Eligible Dependent, subject to the following:
 - (a) A newborn child of a Covered Person will be considered an Eligible Dependent from the moment of birth and will be eligible for benefits for Sickness or Injury, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled as a dependent of the Covered Person within thirty (30) days of the child's date of birth;
 - (b) A spouse will be considered an Eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a dependent of the Covered Person within thirty (30) days of the date of marriage; and
 - (c) A dependent acquired other than at the time of birth due to court order, decree, marriage or placement in the home of the Covered Person while adoption proceedings are pending will be considered an Eligible Dependent from the date of such court order, decree, marriage, or placement, provided that the dependent is properly enrolled as a dependent of the Covered Person within thirty (30) days of the date of the court order, decree, marriage or placement.

- (d) A child enrolled at the beginning of a Plan Year will be considered an Eligible Dependent on the first day of the month following the date of completion of the enrollment application. The Active Service and evidence of good health requirements described in item 2 below do not apply. Pre-Existing Conditions limitations may apply (see the Pre-Existing Conditions section).

In situations where dependent coverage is already in effect prior to the date a Dependent is acquired pursuant to paragraphs (a) and (c) above, the thirty (30) day period described above shall be deemed to be satisfied, provided that the Employee completes the proper enrollment forms within a reasonable time after acquiring the Dependent. No claims will be processed under the Plan until the Dependent is properly enrolled.

- 2. If the application for coverage for an Eligible Dependent is filed more than thirty (30) days after the Eligibility Date determined in accordance with subsection (1) above, the Covered Person must submit, at his/her own expense, evidence of good health of each dependent for whom coverage under the Plan is sought which is satisfactory to the Employer and Contract Administrator. The Eligibility Date for each dependent will then be the first day of the month following the date of approval by the Employer and Contract Administrator of the dependent's evidence of good health.

A dependent shall be covered under the Plan on the date he/she satisfies the Eligibility Requirements as outlined herein, provided he/she is in Active Service on that date. Otherwise, his/her coverage under the Plan shall be deferred until he/she returns to Active Service. In no event will the Eligibility Date for a Dependent precede the Eligibility Date for the Covered Person who determines the Dependent's eligibility for benefits under the Plan.

BENEFITS

Limitations

- 1. **Shared Expenses**
During each calendar year, except where specifically indicated to the contrary, each Covered Person or Covered Dependent shall be responsible for the deductible, copayment and coinsurance requirements listed in the Schedules of Benefits.
- 2. **Maximum Lifetime Benefits While Covered Under This Plan**
The maximum medical benefit while covered under this Plan for any Covered Person or Covered Dependent shall not exceed the amount listed in the Schedule of Medical Benefits.
- 3. **Pre-Existing Conditions**
No benefits will be paid in excess of \$1,000 with respect to Expenses Incurred for a Pre-Existing Condition until the Covered Person or Covered Dependent completes twelve (12) months from the date coverage commenced under the Plan, or, if earlier, from the first day of any required waiting period, reduced by any period of Creditable Coverage. A waiting period means the period that must pass with respect to the initial eligibility of an individual before an otherwise qualified individual may be covered under the Plan.

The above limitation shall not apply to a Covered Person or a Covered Dependent under the following circumstances:

- (a) a Covered Person or Covered Dependent who has been continuously covered under the Plan since the Effective Date of the Plan and who was, on the day prior to such Effective Date, covered under the group plan sponsored by the Employer immediately prior to the Effective Date, to the extent he or she had satisfied a similar provision under such prior plan;

- (b) an Eligible Dependent under age eighteen (18) who was either adopted by a Covered Person or placed in the home of a Covered Person while adoption proceedings with respect to that Dependent are pending, provided such child is covered by the Plan, or otherwise covered by Creditable Coverage, within thirty (30) days of becoming an Eligible Dependent. However, if such Eligible Dependent incurs a sixty-three (63) day period during which he or she is not covered by Creditable Coverage, this exclusion from the Pre-Existing Condition limitation shall no longer apply;
- (c) a newborn, provided such child is covered by the Plan, or otherwise covered by Creditable Coverage, within thirty (30) days of becoming an Eligible Dependent. However, if such Eligible Dependent incurs a sixty-three (63) day period during which he or she is not covered by Creditable Coverage, this exclusion from the Pre-Existing Condition shall no longer apply; or
- (d) a Covered Person or Covered Dependent with respect to the pregnancy of such individual.

Any period of Creditable Coverage shall be applied to reduce the Pre-Existing Condition limitation described in the Plan, except that no Creditable Coverage shall be considered if, after such Creditable Coverage, there occurs a continuous sixty-three (63) day period during all of which the individual was not covered under Creditable Coverage. However, any waiting period that must pass under this Plan or any other plan before the individual is initially entitled to benefits shall not be considered for the purpose of determining such sixty-three (63) day period. In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether such sixty-three (63) day period has occurred.

Periods of Creditable Coverage shall be established through presentation of certificates prepared by an individual's prior group health plan or health insurance issuer. The certificate will describe an individual's period of Creditable Coverage and any applicable waiting period that had to pass under the plan before the individual was initially entitled to benefits. A Covered Person or Covered Dependent has a right to request a Certificate of Creditable Coverage from the prior group health plan or health insurance issuer, if necessary, to properly establish the period of Creditable Coverage. The Employer will assist the Covered Person or Covered Dependent in obtaining this certificate if requested.

A Covered Person or Covered Dependent may request a certificate of Creditable Coverage from this Plan by requesting such certificate in writing from the Contract Administrator. No certificate shall be issued by the Plan if requested more than twenty-four (24) months from the date coverage under the Plan terminated.

4. Maternity Benefits

Expenses Incurred as a result of pregnancy will be eligible for benefits the same as any other Sickness under the Plan, except that the following provisions shall be applicable:

- a minimum of forty-eight (48) hours of inpatient Hospital care for the mother and newborn child shall be provided following a vaginal delivery; and
- a minimum of ninety-six (96) hours of inpatient Hospital care for the mother and newborn child shall be provided following a delivery by Caesarean section.

A shorter inpatient Hospital stay may be provided if a Physician licensed to practice medicine in all of its branches determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and the newborn child meet the appropriate guidelines for a shorter stay, based upon an evaluation of the mother and newborn child and taking into consideration the availability of a post-discharge visit within forty-eight (48) hours following the discharge, with either a Physician in his office or with an RN, or LPN supervised by an RN in the child's home.

A mother and newborn child are considered separate persons for all purposes under the Plan, except that the following services are available for the child even if the mother is covered under the Plan and there is no Dependent coverage in effect at the time of birth to provide benefits under the Plan for the child:

- (a) routine inpatient Hospital nursery charges and inpatient pediatric care;
- (b) routine inpatient examinations by a Physician other than the Physician who delivered the child or administered anesthesia during delivery; and
- (c) Expenses Incurred for circumcision.

5. Mental Illness/Substance Abuse

Notwithstanding any provision herein to the contrary, benefits available for treatment of Mental Illness or for Substance Abuse are limited as described in the Schedule of Benefits. In addition, benefits are only available for treatment of Mental Illness for services provided by or under the direction of a Physician, psychologist or licensed clinical social worker.

Expenses excluded in accordance with this Section shall not apply toward satisfaction of the Shared Expense limitation of the Plan.

6. Post-Mastectomy Care

Coverage is provided for inpatient hospitalization following a mastectomy for a length of time determined by the attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and evaluation of the patient; and for a post-discharge Physician office visit or in-home nurse visit within forty-eight (48) hours after discharge.

7. Autism Spectrum Disorders

Coverage for the diagnosis and Medically Necessary treatment of Autism Spectrum Disorders for a Covered Person or Covered Dependent under twenty-one (21) years of age is provided up to the annual benefit amount required by law. By law, the annual benefit amount may be adjusted annually. To determine the maximum amount available, contact the Customer Service Department at the number on your Plan ID card.

Treatment includes direct, consultative or diagnostic psychiatric care; direct or consultative psychological care; habilitative or rehabilitative care; and therapeutic care. Services must be provided by a Physician, a licensed clinical psychologist with expertise in diagnosing Autism Spectrum Disorders or a certified, registered or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary and ordered by a Physician. Medically Necessary early intervention services are covered when those services are delivered by an early intervention specialist.

Services not directly related to the treatment of autism are not applied to the Plan Year Maximum Benefit for Autism Spectrum Disorders.

8. Benefits Obtained from Preferred Providers

The Employer may enter into one or more Preferred Provider Agreements with certain health care service providers from time to time. Those participating providers are designated as Preferred Providers. As a result, covered services obtained from Non-Preferred Providers are subject to an increased Shared Expense limitation as described in the Schedule of Benefits. This increased Shared Expense limitation shall apply if:

- (a) the medical services are received from a Non-Preferred Provider;
- (b) the basic care or services are available from a Preferred Provider;
- (c) any additional time to transport the patient will not jeopardize the patient's health; and
- (d) the Plan Administrator has not waived this provision due to extenuating circumstances.

However, services provided by a Non-Preferred Provider radiologist, anesthesiologist, pathologist or emergency room Physician are covered at the Preferred Provider shared expense level when the primary Hospital service is rendered by a Preferred Hospital.

A complete listing of Preferred Provider Hospitals is attached as Exhibit A. A complete listing of all Preferred Providers is available free of charge from the Employer and is subject to change at any time.

Medical Benefits

Reasonable and Customary Expenses Incurred on behalf of each Covered Person or Covered Dependent are covered for:

1. Well-Adult Care Services

Unless otherwise noted, covered services will be paid subject to the limitations specified under the Well-Adult Care section of the Schedule of Benefits. Physical examinations (age sixteen (16) or older) and related testing, except as limited below:

- (a) routine hearing examinations (age nineteen (19) or older);
- (b) one (1) routine pap smear, prostate specific antigen test and digital rectal examination each calendar year;
- (c) a screening for colorectal cancer is covered when ordered by your Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. (See the Schedule of Benefits for coverage limitations.)
- (d) Expenses Incurred for bone mass measurement and the diagnosis and treatment of osteoporosis;
- (e) a complete and thorough clinical breast exam to check for lumps and other changes for the purpose of early detection and prevention of breast cancer at least every three years for women at least twenty (20) years of age but less than forty (40) years of age, and annually for women forty (40) years of age or older;
- (f) Screening for the presence of occult breast cancer for women age thirty-five (35) and older through the use of low-dose mammography (including digital mammography) as follows: one baseline mammogram for women age thirty-five (35) to thirty-nine (39) and one mammogram each year for women age forty (40) and older. For women under age forty (40) with a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors, screenings are covered at intervals considered Medically Necessary by the woman's health care Provider. A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue if Medically Necessary as determined by a

Physician. Services received from a Preferred Provider do not apply to any Individual Lifetime Maximum or Plan Year Maximum benefit limitation under the Plan. (See the Schedule of Benefits for coverage limitations.)

2. Well-Child Care Services

Routine physical exams and related testing for Covered Dependent children from birth to age sixteen (16). Coverage does not include immunizations and is subject to the limitations specified on the Schedule of Benefits.

3. Inpatient Hospital Services

(a) Hospital Services:

- (1) regular Room and Board (semi-private room rate);
- (2) confinement in an Intensive Care Unit; and
- (3) Necessary Services and Supplies.

(b) Skilled Nursing Facility Confinement:

- (1) Room and Board, including any charges made by the facility as a condition of occupancy or on a regular daily or weekly basis such as general nursing services (If private room accommodations are used, benefits available for Room and Board will not exceed the average semi-private rate charged by the facility or a representative cross section of similar institutions in the area);
- (2) medical services customarily provided by the Skilled Nursing Facility, with the exception of private-duty or special-nursing services and Physician's fees; and
- (3) drugs, biologicals, solutions, dressings and casts furnished for use during the convalescent period, but no other supplies.

A Covered Person or Covered Dependent shall be eligible for benefits under this subsection only to the extent confinement in a Skilled Nursing Facility:

- (1) is certified by a Physician as essential for recuperation from the Sickness or Injury that caused such Hospital Confinement; and
- (2) is not incurred for custodial care.

(c) Partial Hospitalization Treatment Program:

Treatment in a planned therapeutic treatment program of a Hospital or Substance Abuse Treatment Facility in which patients with Mental Illness or Substance Abuse spend days or nights, provided that admission to the program occurs within seventy-two (72) hours of discharge from Hospital Confinement/Admission for which benefits were available under the Plan. Each two (2) days of partial hospitalization equals one (1) day of care for calculation of the inpatient limitations for Mental Illness/Substance Abuse treatment benefits, as listed on the Schedule of Benefits.

4. Outpatient Services.

Outpatient Treatment: Reasonable and Customary Expenses Incurred for the following Outpatient Treatment:

(a) Surgery and related diagnostic service received on the same day as the Surgery, whether as Outpatient Treatment or in a Physician's office, including Physician's surgical charges;

- (1) diagnostic testing related to Surgery or medical care; and

- (2) services provided in an Ambulatory Surgical Facility.
- (b) Emergency Room Treatment: Reasonable and Customary Expenses Incurred for initial Emergency Treatment of a Sickness or Injury in a Hospital emergency room or by a Physician.
- (c) Pre-Admission Testing: Reasonable and Customary Expenses Incurred for pre-admission testing which is performed either:
 - (1) at a Hospital on an outpatient basis; or
 - (2) at an outpatient facility if the test results are accepted by the Hospital to which the patient is admitted;

provided that such testing is performed as required by your Physician prior to admission to that Hospital on an inpatient basis for treatment in connection with the Sickness or Injury to which the pre-admission testing relates. No benefits are available pursuant to this subsection if the treatment to which the testing relates is postponed, unless such postponement is Medically Necessary.

5. Physician Services

- (a) Physician's services for surgical procedures, diagnostic services, Mental Illness and Substance Abuse treatment;
- (b) Office visits, house calls or visits to a Hospital or facility by a Physician;
- (c) Second surgical opinions and, if the second surgical opinion does not confirm the first opinion, a third opinion is also covered;
- (d) Oral Surgery, as defined herein, including anesthesia and related charges;
- (e) Anesthetics and their administration by a professional anesthetist or anesthesiologist;
- (f) Dental Services rendered by a dentist or Physician which are required as a result of accidental Injury to the jaw, teeth, mouth or face;
- (g) Special treatments, on an in-patient or outpatient basis, if rendered by a Physician or Hospital:
 - (1) X-ray and radiation therapy treatments;
 - (2) chemotherapy;
 - (3) shock therapy treatments;
 - (4) renal dialysis treatments; or
 - (5) allergy shots and allergy surveys.
- (h) Treatment of temporomandibular joint syndrome with intra-oral prosthetic devices, or any other procedure to alter vertical dimension, subject to limitations specified on the Schedule of Benefits.

6. Other Covered Services

- (a) Private duty professional nursing services by a Registered Nurse or Licensed Practical Nurse, but only:
 - (1) on an inpatient basis, if the Employer determines that services provided are of such a nature or degree of complexity or quantity that they cannot be or are not usually provided by the regular nursing staff of the Hospital or other facility; or

- (2) in the home, if the services provided are of such a nature that they cannot be provided by non-professional personnel;
- (b) Physical therapy (whether rendered by a Physician or licensed physical therapist);

Medically Necessary preventive physical therapy for the treatment of multiple sclerosis is covered when prescribed by a Physician for the purpose of treating parts of the body affected by multiple sclerosis but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.
- (c) Services of a qualified Physician or qualified speech therapist for restoratory or rehabilitory speech therapy for speech loss or impairment due to Sickness or Injury or due to a congenital anomaly;
- (d) Services of a Physician or registered occupational therapist for constructive therapeutic activity designed and adapted to promote the restoration of useful physical function;
- (e) Phase I and Phase II cardiac rehabilitation services;
- (f) Local ground transportation provided by a professional ambulance service, to the nearest Hospital, between Hospitals or between a Hospital and a Skilled Nursing Facility, including air ambulance service, when Medically Necessary;
- (g) Processing and administration of blood or blood components, including the cost of the actual blood or blood components, unless replaced;
- (h) The following medical supplies:
 - (1) prosthetic appliances required to replace all or part of an organ or tissue or the function of an organ or tissue, including adjustment, repair or replacement of such devices where required due to wear or a change in the patient's condition, but specifically excluding dental appliances or vision appliances other than cataract lenses or standard glasses required promptly after, and because of, cataract Surgery;
 - (2) durable medical equipment, including such things as internal cardiac valves, internal pacemakers, paraffin baths, bone screws, bolts, nails, plates, wheelchairs, Hospital beds, artificial limbs and other similar devices (rental or purchase, at the option of the Contract Administrator);
 - (3) dressings, sutures, casts, splints, trusses, crutches, braces or other necessary medical supplies, with the exception of dental braces or corrective shoes;
 - (4) oxygen and rental equipment for its administration;
 - (5) leg, back, arm and neck braces when prescribed by a Physician; and
 - (6) charges for drugs which can be obtained only with the written prescription of a Physician, insulin and disposable needles, pursuant to the terms of the drug card program maintained by the Employer with CatalystRx and more fully described in Addendum A. Deductible and copayment expenses paid by a Covered Person or Covered Dependent in accordance with the Schedule of Benefits shall not apply toward satisfaction of any other limitation herein.
- (i) Chiropractic services performed by a chiropractor or Physician;
- (j) Services obtained at a Birthing Center;
- (k) Services for voluntary sterilization for Covered Persons or their spouses (vasectomies when performed in an office setting; tubal ligations when performed in a Facility);

- (l) Treatment of Mental Illness and Substance Abuse;
- (m) Gastric bypass Surgery or lap band Surgery, including all related complications;
- (n) Expenses Incurred for the diagnosis and treatment of Autism Spectrum Disorders, limited to the amount required by law;
- (o) Human papillomavirus (HPV) vaccine;
- (p) Expenses Incurred for Medically Necessary pain medication and pain therapy related to the treatment of breast cancer, subject to the same terms and conditions as other services under the Plan;
- (q) An annual screening for ovarian cancer using CA-125 serum tumor marker testing, trans-vaginal ultrasound or pelvic examination for females who are at risk of ovarian cancer;
- (r) Shingles vaccine for those age sixty (60) and older;
- (s) Medically Necessary rehabilitative services are covered for children under 19 years of age who have been diagnosed with a congenital, genetic or early-acquired disorder by a Physician licensed to practice medicine in all its branches.
 - (1) Rehabilitative services include occupational therapy, physical therapy, speech therapy and other services prescribed by the treating Physician pursuant to a treatment plan to enhance the child's ability to function.
 - (2) Congenital, genetic and early acquired disorders include hereditary disorders, autism or an Autism Spectrum Disorder, cerebral palsy or disorders resulting from illness or Injury, which occurred prior to the child's developing functional life skills, such as walking, speaking or self-care skills.

Treatment must be Medically Necessary and therapeutic. Treatment shall be administered by licensed Providers (speech-language pathologist, audiologist, occupational therapist, physical therapist, Physician, nurse, optometrist, nutritionist, social worker or psychologist) under the direction of the treating Physician.

Treatments that are experimental or investigational are not covered. Services that are solely educational in nature or reimbursed under State or federal law are not covered. Treatment of serious and non-serious Mental Health Care or other mandated benefits are not included under this benefit.

- (t) Diabetic Self-Management Training and Education; equipment, supplies and foot care for the treatment of Type I diabetes, Type II diabetes and gestational diabetes mellitus as follows:
 - (1) covered medical supplies and equipment:
 - (A) blood glucose monitors
 - (B) blood glucose monitors for the legally blind
 - (C) cartridges for the legally blind
 - (D) lancets and lancing devices; and
 - (E) insulin pumps and supplies.
 - (2) covered pharmaceuticals and supplies:

- (A) insulin
- (B) syringes and needles
- (C) test strips for glucose monitors
- (D) FDA-approved oral agents used to control blood sugar, and
- (E) glucagon emergency kits

Notwithstanding the foregoing, any item listed herein that is an eligible expense under the prescription drug card plan shall not be considered an eligible expense under this Section (n).

- (3) regular foot care exams by a Physician, and office visits to a Physician or certified, registered or licensed health care professional with expertise in diabetes management
- (u) Hospice care for terminally ill persons certified by a Physician as having a life expectancy of less than six (6) months, limited as follows:
 - (1) Room and Board;
 - (2) Necessary Services and Supplies at a facility or in the home;
 - (3) part-time nursing care;
 - (4) consultation and case management services by a Physician;
 - (5) physical therapy;
 - (6) medical supplies and prescription drugs otherwise covered by the Plan; and
 - (7) bereavement counseling.

(v) Home Health Care Expense Benefits, as follows:

(1) Benefits

Reasonable and Customary Expenses Incurred for services and supplies furnished in the home of the Covered Person or Covered Dependent in accordance with a Home Health Care Plan for care which begins within three (3) days of a Hospital Confinement/Admission or discharge from a Skilled Nursing Facility.

Expenses covered under this Section include:

- (A) part-time or intermittent nursing care by or under the supervision of a Registered Nurse;
- (B) physical therapy, occupational therapy, respiratory therapy and speech therapy provided by the Home Health Care Agency; and
- (C) medical supplies, drugs and medications prescribed by a Physician, and laboratory services, to the extent such items would have been paid by the Plan if the Covered Person or Covered Dependent had remained in the Hospital or Skilled Nursing Facility.

(2) Limitations

Each visit of four (4) hours or less by a Home Health Care Agency team, shall be considered as one Home Health Care Visit. Home Health Care Visits are limited as described in the Schedule of Benefits. No benefits are payable under this Section for:

- (A) services or supplies not covered by the Home Health Care Plan;
- (B) services performed by an individual who ordinarily resides in the Covered Person's or Covered Dependent's home or is a member of the Covered Person's or Covered Dependent's Immediate Family;

- (C) services of any social worker;
 - (D) Expenses Incurred for transportation; or
 - (E) services or supplies rendered during any period in which the Covered Person or Covered Dependent is not under the continuing care of a Physician.
- (w) Unless otherwise noted, elective breast reconstruction in connection with a mastectomy is covered under the same conditions as any other illness. If there is no evidence of malignancy, coverage is limited to services provided within two (2) years of the date of the mastectomy. Benefits include:
- (1) reconstruction of the breast on which the mastectomy has been performed;
 - (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - (3) prostheses and treatment of physical complications in all stages of mastectomy, including lymphedemas;
- in a manner determined in consultation with the attending Physician and the patient.
- (x) Reasonable and Customary Expenses Incurred for the following named human organ transplants: cornea, kidney, heart, heart/lung, lung, kidney/pancreas, bone marrow, liver, human organ or tissue transplants, subject to the following:
- (1) If both the donor and the recipient are covered by the Plan, each shall have their benefits computed in accordance with the provisions of their own coverage.
 - (2) If the recipient is covered by the Plan and the donor has no other source of benefits, benefits for both the donor and the recipient shall be computed in accordance with the provisions governing the recipient's eligibility for benefits under the Plan.
 - (3) If the donor is covered by the Plan and no benefits are available to the donor from any other source, benefits shall be provided to the donor under the provisions of the Plan, but no benefits shall be provided to the recipient.

Supplemental Plan (Dental/Vision/ Prescription Drug/Wellness Benefit)

If you are covered under another group health plan, the following Supplemental Plan can help you obtain greater benefits. This Supplemental Plan includes the following benefits: Dental, Vision and Prescription Drugs as stated in the Dental, Vision and Prescription Drug sections of this health plan document. It also includes a wellness benefit reimbursement for the Employee, to a maximum of \$400 per calendar year, for the benefits outlined below:

1. routine hearing examinations, physical examinations and related diagnostic testing, except as limited by the plan document;
2. one (1) routine pap smear, prostate specific antigen test and digital rectal examination each calendar year;
3. routine colorectal cancer screenings in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology;
4. Expenses Incurred for bone mass measurement and the diagnosis and treatment of osteoporosis.

5. When received from a Preferred Provider, one (1) routine mammogram each calendar year is covered at no cost to the Covered Person or Covered Dependent. Routine mammograms are not covered when service is received from a Non-Preferred Provider.

Dental Benefits

1. Covered Services

Dental Services covered by the Plan are divided into the following classifications and are paid at the designated percentage of Reasonable and Customary Expenses Incurred as specified on the Schedule of Benefits:

(a) Preventive/Basic Dental Services

- (1) cleaning and scaling teeth but not more often than two (2) per calendar year;
- (2) fluoride application, but not more than two (2) annually, and only for an individual who has not attained age nineteen (19);
- (3) diagnostic services to determine necessary care:
 - (A) routine full-mouth or panoramic X-rays but not more often than once every twenty-four (24) months;
 - (B) bite-wing X-rays but not more often than two (2) annually;
 - (C) diagnostic oral examination but not more often than two (2) annually;
- (4) topical application of sealants, limited to one (1) per tooth annually for an individual who has not attained age nineteen (19);
- (5) Emergency Treatment for relief of dental pain;
- (6) extraction of one or more teeth, cutting procedures in the mouth, and dislocations of the jaw, but not including additional charges for removal of stitches or post-operative examinations;
- (7) space maintainers and their fitting;
- (8) treatment of the gums and supporting structure of the teeth;
- (9) fillings and other restorative services other than gold fillings and gold inlays and onlays;
- (10) root canals and other endodontic treatment;
- (11) local anesthetics and their administration, except for three (3) or less simple extractions;
- (12) injectable antibiotics administered by a dentist; and
- (13) laboratory examinations and tests;
- (14) denture repair, relining, recementing inlays, onlays and crowns.

(b) Major Dental Services

- (1) gold fillings (including inlays and onlays) and crowns necessary to restore the structure of teeth broken down by decay or Injury, except that:
 - (A) the benefit for a crown or gold filling will be limited to the charge for a silver, porcelain or other filling unless the tooth cannot be restored with such other material; and
 - (B) the replacement of a crown or gold filling is covered only if the crown or filling is over five (5) years old.
- (2) full or partial dentures, fixed bridges or adding teeth to an existing denture, if required because of loss of natural teeth or to replace an existing prosthesis which is over five (5) years old and cannot be made serviceable; and

Specialized techniques involving precision attachments, personalization or characterization, and additional charges for adjustments within six (6) months from installation are not included as covered dental charges. Benefits for both a temporary and permanent prosthesis will be limited to the charge for the permanent prosthesis.

(c) Orthodontic Services

Benefits are available under this Section only for Covered Dependents who are at least six (6) years of age at the start of a course of orthodontic treatment. No benefits will be paid for a Covered Dependent upon reaching the age of nineteen (19) years. Coverage includes:

- (1) orthodontia care, treatment and supplies;
- (2) space retainers and other tooth-straightening supplies; and
- (3) other tooth/jaw appliances for purposes of tooth straightening, limited to one (1) annually.

2. Limitations

(a) Shared Expenses/Coinsurance

Notwithstanding any provision herein to the contrary, during each calendar year, a Covered Person or Covered Dependent shall be responsible for a portion of Reasonable and Customary Expenses Incurred pursuant to this Dental Benefits Section as specified in the Schedule of Benefits.

(b) Maximum Dental Benefits

Notwithstanding any provision herein to the contrary, the maximum annual and lifetime dental benefits available for each Covered Person or Covered Dependent shall not exceed the amounts specified in the Schedule of Benefits.

(c) Alternate Benefits

If more than one (1) course of treatment is available, benefits will be computed and paid based on the least costly course of treatment.

(d) Care by More than One (1) Dentist

If a Covered Person or Covered Dependent switches dentists during a particular course of treatment, benefits will be provided as if the course of treatment had been provided under the original treatment plan.

(e) Limitations

The following limitations apply to benefits provided pursuant to this Section in addition to those limitations specified elsewhere in the Plan. Pursuant to these additional limitations, no benefits will be provided under this Section for:

- (1) Dental Services not ordered by a Physician or dentist;
- (2) Dental Services which do not meet the standards set by the American Dental Association;
- (3) Dental Services incurred due to loss or theft of dentures or bridges;
- (4) Dental Services obtained from a health department maintained by the Employer, a union, a trustee or a similar type of entity;
- (5) Dental Services obtained for cosmetic reasons, including altering or extracting and replacing sound teeth to change appearance;
- (6) the following items:
 - (A) myofunctional therapy;
 - (B) athletic mouthguards;
 - (C) implants;
 - (D) oral hygiene, dietary, plaque control and other educational programs;
 - (E) duplicate prosthetic appliances; and
 - (F) porcelain veneered crowns or pontics placed on or in place of a tooth behind the second bicuspid, to the extent the charges would be more than the charges that would have been a Covered Dental Charge for acrylic veneered crowns or onlays;
 - (G) the placement of crowns, inlays, bridges or dentures, or the relining of dentures more than once in a consecutive five (5) year period for the same teeth or missing teeth;
 - (H) charges for failure to keep a scheduled visit with a dentist;
 - (I) maintenance items such as, but not limited to, toothpaste, toothbrushes, floss, polishing paste, soaking solutions;
 - (J) travel to and from the dentist;
- (K) expenses not specifically listed in this Section.

Vision Benefits

Vision care benefits are available for exams, frames, lenses and contact lenses once in a calendar year, subject to the calendar year maximum specified on the Schedule of Benefits. The date of possession of frames, lenses or contact lenses will be the date the expense is incurred.

CLAIM PROVISIONS

Annual Information Statement

An annual information statement must be completed each year by the Covered Person and properly signed as required by the Employer. The completed form must be submitted to the Plan Sponsor. The procedures outlined below must be followed by Covered Persons and Covered Dependents (“Claimants”) to obtain payment of benefits under the Plan.

Benefit Claims

1. Discretion of Plan Administrator

All Claims must be filed with the Contract Administrator or other appropriate entity as directed by the Plan Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such Claims and for providing full and fair review of the decision on such Claims in accordance with the following provisions and with applicable law. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Claimant is entitled to them. The responsibility to process Claims in accordance with the Plan is delegated to the Contract Administrator or other appropriate entity as directed by the Plan Administrator, provided, however, that the Contract Administrator or other appropriate entity, is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Claimant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the Claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

2. When Claims must be Filed

Claims must be filed with the Contract Administrator within one-hundred eighty (180) days after the calendar year end of the date charges for the services were incurred. Benefits are based upon the Plan’s provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date will be denied.**

A Pre-Service Claim is considered to be filed when the request for approval of treatment or services is made and received by the Contract Administrator in accordance with the Plan’s procedures. However, a Post-Service Claim is considered to be filed when the following information is received by the Contract Administrator, together with a Form HCFA or Form UB92 or other approved standardized method:

- (a) the date of service;
- (b) the name, address, telephone number and tax identification number of the provider of the services or supplies;

- (c) the place where the services were rendered;
- (d) the diagnosis and procedure codes;
- (e) the amount of charges;
- (f) the name of the Covered Person; and
- (g) the name of the patient.

Upon receipt of this information, the Claim will be deemed to be filed with the Plan. The Contract Administrator will determine if enough information has been submitted to enable proper consideration of the Claim. If not, more information may be requested as provided herein. This additional information must be received by the Contract Administrator within forty-five (45) days from receipt by the Claimant of the request for additional information. **Failure to do so may result in Claims being denied or reduced.**

3. Timing of Claim Decisions

The Contract Administrator or Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-Service Claims, of decisions that a Claim is payable in full) within the following time frames:

(a) Pre-Service Claims

- (1) If the Claimant has provided all of the information needed to process the Claim, in a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the Claim, unless an extension has been requested then prior to the end of the fifteen (15) day extension period.
- (2) If the Claimant has not provided all of the information needed to process the Claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than five (5) days after receipt of the Claim. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Contract Administrator or Plan Administrator and the Claimant (if additional information was requested during the extension period).

(b) Urgent Care Claims

- (1) If the Claimant has provided all of the information needed to process the Claim, as soon as possible, but not later than 72 hours, unless an extension has been requested, then within 48 hours of the end of the extension period. If the notification is provided orally, a written or electronic notification will be provided to the Claimant within three days after the oral notification.
- (2) If the Claimant has not provided all of the information needed to process the Claim, then the Claimant will be notified as to what specific information is needed within 24 hours of receipt of the Claim. The Claimant will be provided a reasonable amount of time, but not less than 48 hours to provide the specified information. If the requested information is not received within 48 hours the Claim will be denied. The Claimant will be notified of a determination of benefits within 48 hours after receipt of the requested information. If the notification is

provided orally, a written or electronic notification will be provided to the Claimant within three days after the oral notification.

(c) Concurrent Claims

Any reduction or termination of benefits for concurrent care (other than by Plan Amendment or termination) before the end of an approved period of time or number of treatments is considered a Claim denial. The Claimant will be notified in advance of the reduction or termination to allow the Claimant the opportunity to appeal the decision before the benefit is reduced or terminated.

- (1) Claims for concurrent care will be decided within 24 hours of the receipt of the Claim, provided such request is made at least 24 hours before the expiration of the prescribed period of time or number of treatments.
- (2) Claims for concurrent care which are not received at least 24 hours before the expiration of the prescribed period of time or number of treatments will be decided in accordance with the Urgent Care Claims procedures discussed above.

(d) Post-Service Claims

- (1) If the Claimant has provided all of the information needed to process the Claim, in a reasonable period of time, but not later than thirty (30) days after receipt of the Claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.
- (2) If the Claimant has not provided all of the information needed to process the Claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Contract Administrator or Plan Administrator and the Claimant.

(e) Extensions – Pre-Service Claims

The benefit determination period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial fifteen (15) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(f) Extensions – Post-Service Claims

The benefit determination period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial thirty (30) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(g) Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a Claim is deemed to be filed in accordance with the procedures of the Plan.

4. Notification of an Adverse Benefit Determination

The Contract Administrator or Plan Administrator shall provide a Claimant with a notice, either in writing or electronically, containing the following information:

- (a) a reference to the specific portion(s) of the Plan upon which a denial is based;
- (b) specific reason(s) for a denial;
- (c) a description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary;
- (d) a description of the Plan's review procedures and the time limits applicable to the procedures;
- (e) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's Claim for benefits;
- (f) the identity of any medical or vocational experts consulted in connection with a Claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- (g) any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request); and
- (h) in the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or an experimental treatment), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request.

Appeal of Adverse Benefit Determinations

In cases where a Claim for benefits is denied, in whole or in part, and the Claimant believes the Claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a Claim and adverse benefit determination. More specifically, the Plan provides:

1. that claimants have at least one hundred eighty (180) days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and sixty (60) days to appeal a second adverse benefit determination;
2. that claimants have the opportunity to submit written comments, documents, records and other information relating to the Claim for benefits;
3. for a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. for a review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in any prior benefit determination;

5. that, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, 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;
6. for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claim, even if the Plan did not rely upon their advice; and
7. that a Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's Claim for benefits in the possession of the Plan Administrator or the Contract Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

First Appeal Level

1. Requirements for First Appeal

The Claimant must file the first appeal in writing within one hundred eighty (180) days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the Claimant's appeal must be addressed as follows and mailed to: Appeals, P. O. Box 284, Peoria, IL 61650-0284.

It shall be the responsibility of the Claimant to submit proof that the Claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- (a) the name of the Employee/Claimant;
- (b) the Employee/Claimant's social security number;
- (c) the group name or identification number;
- (d) all facts and theories supporting the Claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Claimant will lose the right to raise factual arguments and theories which support this Claim if the Claimant fails to include them in the appeal;
- (e) a statement in clear and concise terms of the reason or reasons for disagreement with the handling of the Claim; and
- (f) any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

2. Timing of Notification of Benefit Determination on First Appeal

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following time frames:

- (a) for Pre-Service Claims, within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the appeal.
- (b) for Post-Service Claims, within a reasonable period of time, but not later than thirty (30) days after receipt of the appeal.

the period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

3. Manner and Content of Notification of Adverse Benefit Determination on First Appeal

The Plan Administrator shall provide a Claimant with notification, in writing or electronically, of the Plan's adverse benefit determination on review, setting forth:

- (a) the specific reason or reasons for the denial;
- (b) reference to the specific portion(s) of the Plan on which the denial is based;
- (c) the identity of any medical or vocational experts consulted in connection with the Claim, even if the Plan did not rely upon their advice;
- (d) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for benefits;
- (e) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, 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 the Claimant upon request;
- (f) if the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided free of charge upon request;
- (g) a description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary;
- (h) a description of the Plan's review procedures and the time limits applicable to the procedures; and
- (i) a statement of the Claimant's right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and

4. Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records and other information described in subsections (c) through (f) of section (3) relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

Second Appeal Level

1. Adverse Decision on First Appeal; Requirements for Second Appeal

Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the Claimant has sixty (60) days to file a second appeal of the denial of benefits. The Claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Claimant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

2. Timing of Notification of Benefit Determination on Second Appeal

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

- (a) for Pre-Service Claims: within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the second appeal.
- (b) for Post-Service Claims: within a reasonable period of time, but not later than thirty (30) days after receipt of the second appeal.
- (c) the period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

3. Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan's response to a second appeal as a first appeal, except for (i) a description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is needed; and (ii) a description of the Plan's review procedures and the time limits applicable to the procedures. See the section titled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

4. Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records and other information described in subsections (c) through (f) of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

5. Decision on Second Appeal to be Final

If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All Claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one (1) year after the Plan's Claim review procedures have been exhausted.

Appointment of Authorized Representative

A Claimant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit Claim or appeal of a denial. An assignment of benefits by a Claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Claimant must complete a form which can be obtained from the Plan Administrator or the Contract Administrator. In the event a Claimant designates an authorized representative, all future communications from the Plan will be with

the representative, rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

Facility of Payment

If a Covered Person or Covered Dependent dies while benefits provided for Hospital, nursing, medical or surgical services remain unpaid, the Contract Administrator may, at its option, make direct payments to the individual or institution on whose charges Claim is based or to the surviving spouse of the Covered Person, or if none, to his or her surviving child or children (including legally adopted child or children) share and share alike, or, if none, to the executors or administrators of the Covered Person's or Covered Dependent's estate.

Minor or Incompetency

If a Covered Person or Covered Dependent is a minor or, in the opinion of the Contract Administrator, not competent to give a valid receipt for payment of any benefit due him or her under the Plan, and if no request for payment has been received by the Contract Administrator from a duly appointed guardian or other legally appointed representative of that person, the Contract Administrator may, at its option, make direct payment to the individual or institution appearing to the Contract Administrator to have assumed the custody or the principal support of that person.

Discharge

Any payment by the Contract Administrator in accordance with these provisions will discharge the Employer and the Contract Administrator from all further liability to the extent of the payment made.

Time Limitations

If any time limitations provided in the Plan for giving notice of claims, furnishing proof of loss, or for bringing any action at law or in equity is less than that permitted by the applicable law, then the time limitation provided in the Plan is hereby extended to agree with the minimum permitted by the applicable law.

Claims Mistakenly Paid

The Contract Administrator shall have the right to recover any payment of claims which have been mistakenly paid on behalf of a Claimant. This includes the right to recover benefits paid on the basis of claims filed which were fraudulently or intentionally misstated by the Claimant. The Claimant will be notified in writing and given an opportunity for review in accordance with the claims procedures herein. A payment by the Contract Administrator in accordance with the Plan is not an admission by the Employer or Contract Administrator that the Expenses Incurred with respect to which a Claim for benefits is filed are eligible for benefits under this Plan.

ADMINISTRATION

Assignment

Benefits under this Plan may be assigned to a provider upon written authorization of the Covered Person or Covered Dependent.

Withholding of Benefit Payments

In the event any question or dispute shall arise as to the proper person or persons to whom any payments shall be made hereunder, the Employer may direct the Contract Administrator to withhold such payments until there shall have been made an adjudication of such question or dispute which in the Employer's sole judgment is

satisfactory to it, or until the Employer and Contract Administrator shall have been fully protected against loss by means of such indemnification agreement or bond as it determines to be adequate.

Medical Examination

The Contract Administrator shall have the right, through a Physician of its choice, to examine a Covered Person or Covered Dependent as often as may be reasonable during the pendency of a Claim hereunder, and the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

The Contract Administrator shall be entitled to receive any and all reports regarding such examinations or autopsies.

Right to Receive and Release Information

The Contract Administrator, pursuant to the reasonable exercise of its discretion or incident thereto, may release to, or obtain from, any other company, organization or person, without consent of, or notice to, any person, any information regarding any person which the Plan Administrator or Contract Administrator deems necessary to carry out the provisions of the Plan, or to determine how, or if, they apply. To the extent that this information is Protected Health Information as described in 45 C.F.R. 164.500, et seq., or other applicable law, the Plan Administrator or Contract Administrator may only use or disclose such information for treatment, payment or health care operations as allowed by such applicable law. Any Claimant under the Plan shall furnish to the Contract Administrator such information as may be necessary to carry out this provision.

The only employees or other persons under the direct control of the Plan Sponsor who are allowed access to the Protected Health Information of other individuals are those employees or persons with direct responsibility for the control and operation of the Plan and only to the extent necessary to perform the duties as Plan Administrator as determined pursuant to the reasonable exercise of discretion of the Plan Administrator.

The employees or classes of employees that will be permitted access to Protected Health Information as set forth in this paragraph are:

Business Manager, Payroll, Bookkeeper, Purchasing

In addition, the Plan Sponsor hereby certifies and agrees that it will:

1. not use or further disclose the information other than as permitted or required by the Plan or as required by law;
2. implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan;
3. ensure that any agents (including subcontractors) to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
4. not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
5. report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. make available Protected Health Information in accordance with 45 C.F.R. 164.524;

7. make health information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. 164.526;
8. make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;
9. make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, et seq.;
10. if feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
11. ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of Protected Health Information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, et seq. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.

Facility of Reimbursement

If payments which should have been made under this Plan have been made under any other plan or plans, the Contract Administrator may, at its sole discretion, pay to any organization making such other payments any amounts which it determines will satisfy the intent of the Plan. Amounts so paid shall be deemed benefits paid under this Plan and, to the extent of such payments, the Employer and Contract Administrator shall be fully discharged from liability under this Plan.

Right to Recovery

If the total payments made by the Contract Administrator as to any expenses at any time are more than the maximum payment then necessary to satisfy the intent of the Plan, the Contract Administrator shall have the right to recover the extra amount of such payments from one or more of the following, as the Contract Administrator will determine: any person to, for or with respect to whom such payments were made, any other insurance companies, and any other organizations.

Subrogation and Reimbursement

1. Payment Conditions

- (a) The Plan, in its sole discretion, may elect, but is not required, to conditionally advance payment or extended credit of medical benefits in those situations where a Sickness, Injury or disability is caused in whole or in part by, or results from, the acts or omissions of a third party or from the acts or omissions of a Covered Person or Covered Dependent (including such Covered Person or Covered Dependent's beneficiaries, heirs or assigns) where any other insurance is available, including, but not limited to, no-fault, uninsured motorist, underinsured motorist, medical payment provisions or other insurance policies or funds ("Coverage").

- (b) The Covered Person or Covered Dependent, his or her attorney, and/or the legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's payment of medical benefits is constructive notice of this provision in its entirety and agrees to maintain one-hundred percent (100%) of the Plan's payment of benefits or the full extent of payment from any one or a combination of first and third party sources in trust and without dissipation except for reimbursement to the Plan or its assignee. By accepting benefits under the Plan, the Covered Person or Covered Dependent agrees that the Plan shall have an equitable lien on any funds received by the Covered Person or Covered Dependent or such person's attorney, if any, from any source and shall be held in trust until such time as the obligation under this provision is fully satisfied.
- (c) In the event a Covered Person or Covered Dependent settles, recovers or is reimbursed by any third party or Coverage, the Covered Person or Covered Dependent agrees to reimburse the Plan for all benefits paid or that will be paid as a result of said Sickness, Injury or disability. If the Covered Person or Covered Dependent fails to reimburse the Plan out of any judgment or settlement received, the Covered Person or Covered Dependent will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money.

2. Subrogation

- (a) As a condition to participating in and receiving benefits under this Plan, the Covered Person or Covered Dependent agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person or Covered Dependent is entitled, regardless of how they are classified or characterized.
- (b) If a Covered Person or Covered Dependent receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any Claim, which any Covered Person or Covered Dependent may have against any party causing the Sickness, Injury or disability to the extent of such payment by the Plan, plus reasonable costs of collection.
- (c) The Plan may, in its own name or in the name of the Covered Person or Covered Dependent or the Covered Person or Covered Dependent's personal representative, commence a proceeding or pursue a Claim against any third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the Plan.
- (d) If the Covered Person or Covered Dependent fails to make a Claim against or pursue damages against:
 - (1) the responsible party, its insurer or any other source on behalf of that party;
 - (2) any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - (3) any policy or contract of insurance from any insurance company or guarantor of a third party;
 - (4) workers' compensation or other liability insurance company; or
 - (5) any other source, including, but not limited to, crime victim restitution funds; any medical, disability or other benefit payments; and no-fault or school insurance coverages;

then the Covered Person or Covered Dependent authorizes the Plan to pursue, sue, compromise or settle any such claims in their name and/or the Plan's name and agrees to fully cooperate with the

Plan in the prosecution of such claims. The Covered Person or Covered Dependent, or his or her guardian or the estate of a Covered Person or Covered Dependent, assigns all rights to the Plan or its assignee to pursue a Claim and the recovery of all expenses from any sources listed above.

3. Right of Reimbursement

- (a) The Plan shall be entitled to recover one-hundred percent (100%) of the benefits paid, without deduction for attorneys' fees and costs, or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, and without regard to whether the Covered Person or Covered Dependent is fully compensated by his or her recovery from all sources. The obligation exists whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability or other expenses. The obligation exists regardless of how it is classified or characterized. If the Covered Person or Covered Dependent's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
- (b) The Plan's equitable subrogation lien specifically supersedes all common law or statutory rules and doctrines such as the "make whole doctrine," the "common fund doctrine" and the law of any state prohibiting any assignment of rights, which interfered with, or compromises in any way, the Plan's equitable subrogation lien.
- (c) The Plan will not pay or be responsible for any expenses, attorney's fees, costs or other monies incurred by the attorney for the Covered Person or Covered Dependent or his or her beneficiaries, commonly known as the common fund doctrine. No court costs, expert's fees, attorney's fees, filing fees or other costs or expenses of a litigation nature may be deducted from the Plan's recovery without the prior written consent of the Plan.
- (d) The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or Claim on the part of the Covered Person or Covered Dependent, whether under the doctrines of causation, comparative fault or contributory negligence, or any other similar doctrine in law. Accordingly, any lien reduction statutes which attempt to apply such laws and reduce a subrogating Plan's recovery for any reason will not be applicable to the Plan and will not reduce the Plan's subrogation recovery.
- (e) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person or Covered Dependent.
- (f) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury or disability.

4. Excess Insurance

- (a) If, at the time of Sickness, Injury or disability, there is available, or potentially available (based on information known or provided to the Plan, to the Covered Person or Covered Dependent) any other Coverage (including, but not limited to, Coverage resulting from a judgment at law, or settlements) the benefits under this Plan shall apply only as excess insurance over such other sources of Coverage. The Plan's benefits shall be excess to:
 - (1) the responsible party, its insurer or any other source on behalf of that party;
 - (2) any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

- (3) any policy of insurance from any insurance company or guarantor of a third party;
- (4) workers' compensation or other liability insurance company; or
- (5) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

5. Wrongful Death Claims

In the event that the Covered Person or Covered Dependent dies as a result of his or her injuries and a wrongful death or survivor Claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights still apply.

6. Obligations

It is the Covered Person's or Covered Dependent's obligation to:

- (a) cooperate with the Plan or any representatives of the Plan, in protecting its rights of subrogation and reimbursement, including completing discovery, attending depositions, and/or attending or cooperating in trial in order to preserve the Plan's subrogation rights;
- (b) provide the Plan with pertinent information regarding the Sickness, Injury or disability, including accident reports, settlement information and any other requested additional information;
- (c) take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- (d) do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- (e) promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- (f) not settle, without the prior consent of the Plan, any Claim that the Covered Person or Covered Dependent may have against any legally responsible party or Coverage to the extent the Plan is or may be entitled to any part of such settlement proceeds.

Failure to comply with any of these requirements by the Covered Person or Covered Dependent, his or her attorney or guardian may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits, and any funds or payments due under this Plan may be withheld until the Covered Person or Covered Dependent satisfies his or her obligation. If the Covered Person or Covered Dependent fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Sickness, Injury or disability, out of any proceeds, judgment or settlement received, the Covered Person or Covered Dependent will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person or Covered Dependent.

7. Minor Status

- (a) In the event the Covered Person or Covered Dependent is a minor (as that term is defined by applicable law), the minor's parents or court-appointed guardian shall cooperate in any and all actions requested by the Plan to seek and obtain any requisite court approval in order to bind the minor and his or her estate insofar as the subrogation and reimbursement provisions are concerned.

- (b) If the minor's parents or court-appointed guardian fail or refuse to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

8. Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation/reimbursement rights.

9. Severability

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

Coordination of Benefits

In addition to benefits payable under this Plan, a Covered Person or Covered Dependent may be entitled to benefits from other plans, payable on account of the same Sickness or Injury. The other plans are those which provide benefits or services for, or by reason of, medical or dental care or treatment, when such benefits or services are provided on a group basis, whether insured or not, by any government or tax-supported program (including Medicare) or any similar plan or program.

This provision is applicable when the total benefits that would be payable in the absence of any coordination of benefits provision under this Plan and under all plans covering an individual exceed the total Expenses Incurred.

One of the two or more plans involved is the Primary Plan and the other plans are Secondary Plans. The Primary Plan pays benefits first and without consideration of the other plans. The Secondary Plans then make up the difference up to the total allowable Expenses Incurred. No plan will pay more than it would have paid without this special provision.

The following rules apply to determine which plan is Primary and which plan is Secondary:

1. If one plan has no coordination of benefits provision, it is automatically Primary.
2. A plan will be Primary if it covers the individual as an employee and Secondary if it covers the individual as a dependent.
3. If an individual is covered as a dependent under two or more plans, the plan which covers the individual as a dependent of the person whose birthday falls earlier in the year is Primary. If both individuals share the same date of birth, the plan covering the individual for the longer period of time is Primary.
4. In the case of children of divorced parents, in the absence of court-determined responsibility, the plan covering the parent with custody is Primary. If the parent without custody has court-determined responsibility, but does not have health benefits available for children, then the plan covering the parent with custody is Primary.

5. A plan will be Primary if it covers the individual as an employee and Secondary if it covers the individual as (i) a former employee, (ii) a retiree, or (iii) an individual who has elected to continue benefits under the Plan pursuant to the Continuation of Benefits Sections herein.
6. If none of the above rules apply, a plan will be Primary if it has covered the individual for the longer period of time and Secondary if it has covered the individual for the shorter period of time.

Notwithstanding any provision herein to the contrary, if a Covered Person or Covered Dependent is eligible for Medicare, benefits otherwise payable on behalf of that Covered Person or Covered Dependent shall be reduced by the amount of benefits available from Medicare, regardless of whether such benefits are actually received from Medicare.

Information necessary to the administration of this Section will be required at the time a Claim is submitted.

Coordination with Medicare, Medicaid and SCHIP

1. Medicare

This Plan will be considered the Primary Plan for Covered Persons who are current Employees and their Covered Dependents who are nevertheless eligible for Medicare benefits if (i) such Covered Persons or Covered Dependents are age sixty-five (65) or older and their Employer employs twenty (20) or more Employees, or (ii) such Covered Persons or Covered Dependents are disabled and any Employer under this Plan employs one hundred (100) or more Employees. Except to the extent required by law for end stage renal disease, Medicare shall be considered the Primary Plan for all other Covered Persons who become eligible for Medicare and their Covered Dependents, unless the Covered Person on behalf of himself or herself and his/her Covered Dependents rejects coverage under this Plan. In the event of an election to terminate coverage, benefits will no longer be available under this Plan as either a Primary Plan or a Secondary Plan.

2. Medicaid and SCHIP

Payment for Expenses Incurred with respect to a Covered Person or Covered Dependent under the Plan will be made in accordance with any assignment of rights made by, or on behalf of, such Covered Person or Covered Dependent as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) or a State Child Health Insurance Program (SCHIP) approved under Title XXI of such Act. In enrolling or in determining or making any payments for Expenses Incurred of a Covered Person or Covered Dependent, the fact that the Covered Person or Covered Dependent is eligible for, or is provided medical assistance under, a State plan for medical assistance approved under Title XIX or a State Child Health Insurance Program approved under Title XXI of the Social Security Act will not be taken into account. To the extent that payment has been made under a State plan for medical assistance approved under Title XIX or a State Child Health Insurance Program approved under Title XXI of the Social Security Act when the Plan has a legal liability to make payment for the Expenses Incurred constituting such assistance, payment for the Expenses Incurred under this Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Covered Person or Covered Dependent to such payment for such Expenses Incurred.

Case Management

In the case where the patient's condition is expected to be, or is of, a serious nature, the Employer or Contract Administrator, pursuant to the reasonable exercise of its discretion, may arrange for review and/or case management services from a professional qualified to perform such services. Upon the advice of such professional, the Contract Administrator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost-effective result can be achieved without a sacrifice to quality of patient care.

Qualified Medical Child Support Order

The Plan shall comply with the terms of a Qualified Medical Child Support Order (“QMCSO”), directing the Plan to provide benefits to one or more alternate recipients, pursuant to the procedure set forth below:

1. An order which purports to be a QMCSO must be served on the Contract Administrator.
2. The Contract Administrator shall, within twenty (20) days of its receipt of the order, make a preliminary determination as to whether or not the order satisfies the requirements to be a QMCSO. In order to satisfy those requirements, an order must contain at least the following information:
 - (a) a clause which creates or recognizes the existence of a Dependent’s right to receive benefits under the Plan;
 - (b) the name and last known mailing address of the Covered Person with respect to whom the order is issued and each dependent covered by the order;
 - (c) a reasonable description of the type of coverage to be provided by the Plan to each Dependent;
 - (d) the time period to which the order applies; and
 - (e) the order does not require the Plan to provide any type or form of benefit not otherwise provided under the Plan.
3. An order which, in the judgment of the Contract Administrator, does not meet the requirements of a QMCSO shall be returned to the legal counsel who prepared the order for revision. Revised orders which are resubmitted shall be considered new orders and shall be reviewed in accordance with the procedures set forth in this Section.
4. When the Contract Administrator makes a preliminary determination that an order satisfies the requirements of a QMCSO, it shall forward the order to the Employer for review. The Employer shall make the final determination of the status of the order.
5. The Contract Administrator shall notify all parties involved (including a designated representative of the Covered Dependent) of the Employer’s decision and of the respective parties’ entitlement to benefits.
6. If it is determined that the order is not a Qualified Order, each named child may appeal that decision by submitting a written letter of appeal to the Plan Administrator.

Reimbursement of benefit payments under the Plan pursuant to a QMCSO may be made to the Covered Dependent or the Covered Dependent’s custodial parent.

Termination of Coverage

1. Termination of Covered Person Coverage

The coverage of any Covered Person with respect to himself/herself shall automatically cease, except as provided in any extension of benefits or continuation of benefits provision, upon the earliest of:

- (a) the date the Plan is terminated, or – with respect to a specific benefit – the date the specific benefit is terminated;

- (b) the last day of the month the Covered Person ceases to be in a class of Employees eligible for coverage;
- (c) the last day of the month for which the Covered Person has failed to make any required contribution for coverage;
- (d) the last day of the month on which the Covered Person's employment with the Employer terminates; or
- (e) the date of the Covered Person's death.

Notwithstanding subsections (b) and (d) above, coverage will terminate at the end of August for any Covered Person who completes the spring semester, if that Covered Person:

- (a) resigns or retires from the Employer;
- (b) is granted a leave of absence, approved by the Board of Education of the Employer (unless such leave is granted pursuant to the Family and Medical Leave Act);
- (c) is released as a result of non-renewal of employment with the Employer; or
- (d) is released as a result of a reduction in force by the Employer.

2. Termination of Covered Dependent Coverage:

The coverage of any Covered Dependent shall automatically cease, except as provided in any extension of benefits or continuation of benefits provision, upon the earliest of:

- (a) the date coverage terminates for the Employee upon whom the Covered Dependents depends for eligibility;
- (b) the date such dependent ceases to be an Eligible Dependent as defined herein;
- (c) the date the Plan is modified to terminate dependent coverage;
- (d) the date beginning the period for which the Covered Person or Covered Dependent has failed to make any required contribution for dependent coverage, if contributions are required;
- (e) the date the Dependent child becomes eligible for coverage under the Plan as an Employee;
- (f) the date the Plan is terminated or – with respect to a specific benefit – the date the specific benefit is terminated; or
- (g) the date of the Covered Dependent's death.

Extension of Benefits

If coverage under the Plan would otherwise terminate with respect to a Covered Person or Covered Dependent, without regard to the continuation of benefits provisions of the Plan, benefits under the Plan can nevertheless be extended under the specific circumstances enumerated below. Any extension of benefits period provided pursuant to this Section shall not postpone the starting date for measurement of the maximum period available for continuation of benefits pursuant to the Continuation of Benefits Section.

1. Handicapped Child

The maximum age for a Dependent child, as specified in this Plan shall not serve to terminate or preclude coverage for any child who is incapable of self-sustaining employment by reason of mental or physical handicap provided:

- (a) such child is dependent upon the Employee for support and maintenance;
- (b) such child was a Covered Dependent and was suffering from such mental or physical handicap on the date his or her status as a Covered Dependent would otherwise terminate; and
- (c) proof of such incapacity is furnished to the Employer (i) within thirty (30) days following the date his or her status as a Covered Dependent would otherwise terminate, and (ii) at such times as the Employer may reasonably require of the Covered Person on the child's behalf.

2. State Mandate, Collective Bargaining Agreement or Employer Personnel Policy

If coverage under the Plan would otherwise terminate with respect to a Covered Person or Covered Dependent, benefits will continue to be provided for those individuals to the extent required by law, a collective bargaining agreement in effect with respect to the Employer or the Employer's personnel policies.

General Limitations

In addition to any limitations or exclusions stated elsewhere in the Plan, no benefits are payable under this Plan for Expenses Incurred:

1. for charges which exceed the Reasonable and Customary charge for the service rendered or charges for which payment is not legally required;
2. for treatment paid for by any agency of the United States Government or any state or political subdivision, or provided by or in a Hospital operated by any agency of the United States Government or any state or political subdivision, unless the Covered Person or Covered Dependent is legally required to pay such charges;
3. for or in connection with:
 - (a) Sickness or Injury for which the Covered Person or Covered Dependent is entitled to benefits under any workers' compensation law, employers' liability law or similar laws;
 - (b) Hospital, surgical and medical services or supplies unless such expense is incurred upon the recommendation of a Physician for diagnosis or treatment of an Injury or Sickness;
 - (c) Injury or Sickness arising out of war (declared or undeclared) or service in any military forces or civilian non-combatant unit serving with such forces;

The limitations of this section shall not apply unless there is a direct causal relationship between the activity described in (i) or (ii) and the Sickness or Injuries sustained;

- (e) services or supplies which constitute personal comfort or beautification items, television or telephone use, education or training, or expenses actually incurred by persons who are not Covered Persons or Covered Dependents;

- (f) cosmetic Surgery, except for treatment necessitated by accidental Injury or for correction of a congenital malformation of a Dependent child;
- (g) services performed by any person who is a member of the Covered Person's or Covered Dependent's Immediate Family, or who normally resides in the Covered Person's or Covered Dependent's home;
- (h) suicide, attempted suicide or intentionally self-inflicted Injury or Sickness (to the extent allowed by law);
- (i) services, supplies or treatments not Medically Necessary for the diagnosis and/or treatment of an active Sickness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value; or drugs not approved for use by the U.S. Food and Drug Administration;
- (j) charges incurred outside the United States if the Covered Person or Covered Dependent traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies;
- (k) hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations, school physical examinations, immunizations or tests not connected with the actual Sickness or Injury, except as otherwise specified herein;
- (l) the purchase or fitting of eyeglasses, contact lenses, hearing aids or such similar aid devices except as otherwise specified herein. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract Surgery;
- (m) replacement of cataract lenses when a prescription change is not required;
- (n) professional nursing services if rendered by other than a Registered Nurse or Licensed Practical Nurse, unless such care was vital as a safeguard of the Covered Person's or Covered Dependent's life, and unless such care is specifically listed as a benefit elsewhere in the Plan;
- (o) treatment of obesity and weight reduction by diet control, Surgery (except as otherwise specifically provided herein, with prior authorization of Medical Necessity) or behavior modification with or without medications;
- (p) diagnosis or treatment of infertility, or restoration or enhancement of fertility, including, but not limited to, therapeutic injections, fertility and other drugs, Surgery, artificial insemination, in-vitro fertilization or surgical reversal of elective sterilization;
- (q) contraceptive medications, devices or appliances, including the administration of any contraceptive medication, unless Medically Necessary, except as provided through Addendum A;
- (r) IQ testing or educational testing;
- (s) vitamins or dietary supplements;
- (t) elective abortions, except where necessary to preserve the life of the mother;
- (u) housekeeping or custodial care;

- (v) weak, unstable or flat feet, or bunions, unless an open cutting operation is performed; or for treatment of corns, calluses or toenails, unless at least part of the nail root is removed; or purchase of orthopedic shoes or other devices for support of the feet;
- (w) treatment of temporomandibular joint syndrome with intraoral prosthetic devices, or any other procedure to alter vertical dimension in excess of \$1,000 per calendar year;
- (x) enrollment in a health, athletic or similar club or weight loss, non- smoking or similar programs, except as otherwise specifically provided herein;
- (y) purchase or rental of supplies of common use such as: exercise cycles, air purifiers, air conditioners, water purifiers, hypoallergenic pillows or mattresses or waterbeds;
- (z) purchase or rental of: motorized transportation equipment, escalators or elevators, saunas, steambaths, swimming pools or blood pressure kits;
- (aa) sex transformation and hormones related to such treatment, or penile implants;
- (bb) chelation therapy;
- (cc) Expenses Incurred for special education or training for learning disabilities;
- (dd) radial keratotomy, keratoplasty or other eye Surgery to correct near- or far-sightedness;
- (ee) Expenses Incurred for behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness;
- (ff) Expenses denied by another health care plan or HMO for lack of pre-treatment approval, improper Claim filing procedures or lack of additional Physician opinions;
- (gg) Viagra or other treatment for sexual impotence;
- (hh) therapy, services or supplies for sexual dysfunction;
- (ii) removal of benign moles, nevi or lesions;
- (jj) otoplasty or blepharoplasty;
- (kk) Dental Services except as provide herein;
- (ll) court ordered treatment;
- (mm) smoking cessation programs or medications;
- (nn) hair prostheses (e.g., wigs and hair pieces);
- (oo) Hospital admission for back pain, or Hospital charges for the removal of teeth unless approved in writing by the Claim Administrator;
- (pp) Expenses Incurred for care, services or treatment required as a result of complications from a treatment not covered under the Plan;

- (qq) any taxes or other assessments owed with respect to Expense Incurred for medical services (other than sales tax);
 - (rr) any limitations on benefits contained in the Schedule of Benefits; or
 - (ss) services and supplies not specifically mentioned in the Plan.
4. for “experimental treatment” for a Covered Person or Covered Dependent. For the purpose of this section, a treatment or procedure shall be deemed an “experimental treatment” when the treatment or procedure involved is given that designation or a similar designation in connection with the administration of Medicare. In addition, a transplant procedure shall be deemed an “experimental treatment” if it is not one of the procedures specified in the Medical Benefits section.

CONTINUATION OF BENEFITS

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), continuation coverage under the Plan is available to Qualified Beneficiaries under certain specified conditions.

For the purpose of this Section, “Qualified Beneficiary” means any beneficiary defined as such pursuant to Section 607(3) of ERISA, and generally includes any Covered Person or Covered Dependent whose coverage under the Plan would otherwise terminate upon occurrence of any of the events specified in this Section. A Qualified Beneficiary also includes a child who is born to, or placed for adoption with, the Covered Person during the continuation coverage elected under this Section, provided such child qualifies as an Eligible Dependent.

Eligibility to Make Election

A Qualified Beneficiary may elect to continue coverage under the Plan if coverage would otherwise cease under the Plan due to:

1. the Covered Person’s death;
2. termination of the Covered Person’s employment or reduction of the Covered Person’s hours (whether voluntarily or involuntarily);
3. divorce or legal separation of the Covered Person and his or her spouse;
4. the Covered Person becoming entitled to Medicare benefits;
5. a Covered Person’s child ceasing to be an Eligible Dependent; or
6. a proceeding in bankruptcy under Title 11, United States Code, commencing on or after July 1, 1986, with respect to the Employer if the Covered Person is a retiree.

Notwithstanding the above, a Qualified Beneficiary is not entitled to elect continuation coverage if the Covered Person’s termination of employment is for gross misconduct as determined by the Employer. In the case of bankruptcy proceedings as described in (6) above, a loss of coverage includes a substantial elimination of coverage with respect to a Qualified Beneficiary within one (1) year before or after the date of commencement of the proceedings.

Election Period and Procedure

The election to continue coverage must be made during the period beginning on the day when coverage would otherwise cease under the Plan and ending sixty (60) days after the later of (i) such date, or (ii) if applicable, under the Administrative Section, the date when the Qualified Beneficiary is notified of the right to make such election. A Qualified Beneficiary's failure to comply with the procedures and requirements established by the Employer for making the election, as described herein or in the Employer's notice of election, shall constitute the failure to make an election to continue coverage as provided herein. The written waiver by a Qualified Beneficiary (or by the Covered Person or his or her spouse on behalf of a Qualified Beneficiary) of the election to continue coverage shall terminate the Qualified Beneficiary's right to later make an election, unless the Qualified Beneficiary revokes the waiver within the sixty (60) day election period described above. However, if a waiver is revoked, continuation coverage will be effective on the date the revocation is made and will not be retroactive to the date of the event described in the Eligibility to Make Election Section.

Benefits

A Qualified Beneficiary who elects continuation coverage as provided herein shall be eligible to receive the same benefits to which a Covered Person or Covered Dependent under similar circumstances is otherwise entitled. If benefits under the Plan are increased, decreased or otherwise amended or changed either prior to or subsequent to the Qualified Beneficiary's election of continuation coverage, each Qualified Beneficiary will be entitled to benefits comparable to those available to a Covered Person or Covered Dependent under similar circumstances.

Payment for Benefits

A Qualified Beneficiary is required to contribute toward the cost of continuing the benefits as provided herein ("Continuation Premium"). The amount of the Continuation Premium or schedule of Continuation Premiums for different classes of Qualified Beneficiaries shall be determined from time to time by the Employer. The Employer shall also establish procedures for the billing and payment of the Continuation Premium which shall be described in the Employer's notice of election form. A Qualified Beneficiary's failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such a period) shall result in the Qualified Beneficiary's termination of continuation coverage as of the date covered by the last paid Continuation Premium, and such Qualified Beneficiary shall be precluded from extending, renewing, or reelecting such continuation coverage.

Duration of Continuation Coverage

A Qualified Beneficiary electing to purchase continuation coverage under the Plan shall be eligible to continue coverage until the earliest of the following events:

1. the date eighteen (18) months after the date of a Covered Person's termination of employment or reduction in hours;
2. the date thirty-six (36) months after the date of any other event described in the Eligibility to Make Election Section other than a Covered Person's termination of employment or reduction in hours (except that if a Covered Person who is an Employee has a termination of employment or reduction in hours entitling him or her to continuation coverage within eighteen (18) months of the date of his or her entitlement to Medicare then the period of Continuation Coverage for the Qualified Beneficiaries other than the Covered Person shall not terminate prior to the close of the thirty-six (36) month period beginning on the date the Covered Person became entitled to Medicare);
3. the date the Employer ceases to provide any health benefit plan for any of its Employees;

4. the date the Qualified Beneficiary first becomes covered after the date of his or her election of continuation coverage (as an employee or otherwise) by another group health plan which does not contain any applicable exclusion or limitation with respect to any Pre-Existing Condition of such Qualified Beneficiary, or the date the Qualified Beneficiary becomes entitled to benefits under Medicare;
5. the date which is the last day of the period for which the Qualified Beneficiary's Continuation Premium payments have been paid (regardless of any grace period if the Employer establishes such a period) as determined by the Employer; or
6. in the case of a Qualified Beneficiary who is determined, under Title II or XVI of the Social Security Act ("Act"), to have been disabled at any time during the first sixty (60) days of continuation coverage, the earlier of (i) the date twenty-nine (29) months after the date of the commencement of such continuation coverage (but only if the Qualified Beneficiary has provided notice of such determination under ERISA Section 606(3) within sixty (60) days of the receipt of the determination notice under the Act and before the expiration of eighteen (18) months from the date of occurrence of the qualifying event) or (ii) the end of the month next following the date of final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.

If more than one event that would entitle the Qualified Beneficiary to elect continuation coverage occurs (as described in the Eligibility to Make Election Section herein), the first occurring of such events shall be the measuring date for purposes of the maximum possible length of continuation coverage under this Section. In addition, the maximum period available for continuation coverage pursuant to the Continuation of Benefits Section is measured from the date of occurrence of the qualifying event specified in the Eligibility to Make Election Section, except where specifically indicated to the contrary.

Administration

1. Notice on Death, Termination, Reduction of Hours or Entitlement to Medicare

Within thirty (30) days of a Covered Person's death, termination of service, reduction of hours or entitlement to Medicare, the Employer shall inform the Plan Administrator of:

- (a) the Qualified Beneficiaries eligible to elect continuation coverage;
- (b) the event precipitating such notice; and
- (c) the date of the event.

The COBRA Notice Coordinator, at the direction of the Employer, shall then notify the Qualified Beneficiaries of their rights to elect continuation coverage pursuant to procedures established by the Employer and applicable law.

2. Notice of Change in Marital Status or Dependent Status

If a Covered Dependent ceases to be eligible for coverage under the Plan because that person becomes divorced or legally separated from the Covered Person, or if a child of a Covered Person ceases to be eligible for coverage under the Plan because he or she is no longer an Eligible Dependent, either the Covered Person, the Covered Person's former spouse or the Covered Person's child must notify the COBRA Notice Coordinator of these events within sixty (60) days of their occurrence in order for the respective Qualified Beneficiary to be eligible to elect continuation coverage. The notice may be provided to the COBRA Notice Coordinator orally or in writing and must disclose:

- (a) the names and Plan identification numbers of the Covered Person and the individuals affected by

the event;

- (b) proof of the individual's divorce, separation or loss of status as an Eligible Dependent; and
- (c) the date of such event.

Notice by a Qualified Beneficiary of the occurrence of an event giving rise to an election does not act as an election to receive continuation coverage under the Plan. In the event of divorce, legal separation or change in Dependent status, the COBRA Notice Coordinator, if notified within the time period specified in this subsection (2), shall notify the Qualified Beneficiaries of their eligibility to elect continuation coverage.

3. Notice of Disability

If a Covered Person or Covered Dependent is determined, under Title II or XVI of the Act to have been disabled at any time during the first sixty (60) days of continuation coverage, the Covered Person or Covered Dependent as the case may be must notify the COBRA Notice Coordinator of the determination under the Act within sixty (60) days of the latest of the following to occur:

- (a) the date of the Social Security Administration disability determination (sometimes referred to as the "award letter");
- (b) the date of the termination of employment or reduction in hours entitling the Qualified Beneficiary to COBRA continuation coverage;
- (c) the date the Qualified Beneficiary otherwise loses coverage under the Plan as a result of the termination of employment or reduction in hours; or
- (d) the date the Qualified Beneficiary is informed of the obligation to provide notice of disability as provided herein.

Notwithstanding the above, the notice of determination must be provided to the COBRA Notice Coordinator before the expiration of eighteen (18) months from the date of occurrence of the termination of employment or reduction in hours. The notice must be provided to the COBRA Notice Coordinator in writing and must disclose (i) the name and Plan identification number of the disabled Covered Person or Covered Dependent, and (ii) the determination notice provided pursuant to the Act to the disabled Covered Person or Covered Dependent. The Qualified Beneficiaries must also notify the COBRA Notice Coordinator in writing within thirty (30) days of the date of any final determination under the Act that the Covered Person or Covered Dependent is no longer disabled. The notice shall disclose (i) the name and Plan identification number of the disabled Covered Person or Covered Dependent, and (ii) the final determination Notice provided pursuant to the Act that the person is no longer disabled.

4. Notice of Coverage Under Group Health Plan or Entitlement to Medicare

If a Qualified Beneficiary (i) becomes covered (as an employee or otherwise) by another group health plan which does not contain any applicable exclusion or limitation with respect to any Pre-Existing Condition of such Qualified Beneficiary, or (ii) becomes entitled to benefits under Medicare, the Qualified Beneficiary must notify the COBRA Notice Coordinator of such event in writing within thirty (30) days of such coverage date.

5. General

- (a) Multiple Events. If more than one event described in the Eligibility to Make Election Section occurs, the first such event occurring will determine which one of either Subsection (1) or (2) of this Section is applicable.

- (b) Notices to Employer. Notices to the COBRA Notice Coordinator shall be provided to the COBRA Notice Coordinator listed in the General Information section. If no COBRA Notice Coordinator is listed in the General Information section then the Employer shall be considered the COBRA Notice Coordinator and notices shall be provided to the person or organizational unit of the Employer that customarily handles employee benefit matters of the Employer.
- (c) Current Addresses. The notification of election rights under COBRA will generally be made by U.S. Mail to the Qualified Beneficiary's last known address. As a result, it is important for each Covered Person and Covered Dependent to timely provide the Employer with his or her current mailing address.
- (d) Interpretation. In the event of any inconsistency or omission, this Section and the applicable provisions of the Plan shall be construed, interpreted and administered in a manner which meets the minimum requirements of COBRA.

MILITARY LEAVE

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), continuation coverage under the Plan is available to Covered Persons and their Covered Dependents under certain specified conditions. Any extension of benefits period provided pursuant to this Section shall not postpone the starting date for measurement of the maximum period available for continuation of benefits pursuant to the Continuation of Benefits Section described above.

Election and Duration of Coverage

A Covered Person may elect to continue coverage under the Plan for himself or herself and his/her Covered Dependents if coverage would otherwise cease under the Plan due to that person's absence from employment with the Employer by reason of his or her service in the uniformed services. The maximum period of coverage available to all Covered Persons and Covered Dependents under the provisions of this Section shall be the lesser of:

1. the twenty-four (24) month period beginning on the date on which the Covered Person's military leave began; or
2. the day after the date on which the Covered Person fails to apply for or return to a position of employment with the Employer following the expiration of the leave as set forth in Section 4312(e) of USERRA.

Benefits

Benefits under the Plan for Covered Persons and Covered Dependents under an election for military leave continuation coverage shall be the same coverage as provided to all other Covered Persons and Covered Dependents. If Benefits under the Plan are increased, decreased or otherwise amended or changed either prior to or subsequent to, the election of continuation coverage, the benefits provided pursuant to this continuation coverage will be the same as those available to all other Covered Persons and Covered Dependents.

Payment for Benefits

A Covered Person is required to contribute toward the cost of continuing the benefits as provided herein ("Continuation Premium"). The amount of the Continuation Premium or schedule of Continuation Premiums for different classes of coverage shall be determined from time to time by the Employer. The Employer shall also establish procedures for the billing and payment of the Continuation Premium. A Covered Person's failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such

a period) shall result in the termination of continuation coverage as of the date covered by the last paid Continuation Premium and such Covered Person shall be precluded from extending, renewing or reelecting such continuation coverage.

Employee Returning from Military Leave

In the case of a Covered Person whose coverage under the Plan was terminated by reason of service in the uniformed services, the Covered Person and his or her Eligible Dependents shall again be eligible for coverage under the Plan immediately upon return to active work. In addition, no other Plan limitation or exclusion shall apply to such returning Employee and his or her Eligible Dependents to the extent that such limitation or exclusion would not have applied had the Employee remained on the Plan during the military leave period. However, the preceding sentence shall not apply to the coverage of any Sickness or Injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

FAMILY AND MEDICAL LEAVE and VICTIMS' ECONOMIC SECURITY AND SAFETY LEAVE

In accordance with the Family and Medical Leave Act of 1993 (FMLA) and the Victims' Economic Security and Safety Act (VESSA), continuation coverage under the Plan is available to Covered Persons and their Covered Dependents under certain specified conditions.

A Covered Person who takes a leave of absence under applicable provisions of FMLA or VESSA is entitled to continued coverage under the Plan for himself or herself and his/her Covered Dependents. Benefits under the Plan are available to the same extent as if the Covered Person had been actively at work during the entire leave period, subject to the following terms and conditions:

1. Coverage shall cease for a Covered Person (and his Covered Dependents) for the duration of the leave if at any time the Covered Person is more than thirty (30) days late in paying any required contribution.
2. A Covered Person who declines coverage during the leave or whose coverage is terminated as a result of his failure to pay any required contributions shall, upon return from the leave, be entitled to be reinstated to the Plan on the same terms as prior to taking the leave, without any qualifying period, physical examination or exclusion of Pre-Existing Conditions.
3. With respect to an FMLA Leave, if a Covered Person who is a Key Employee does not return from leave when notified by the Employer that substantial or grievous economic injury will result from his or her reinstatement, the Key Employee's entitlement to Plan benefits continues unless and until the Covered Person advises the Employer that he or she does not desire restoration to employment at the end of the leave period, or the leave entitlement is exhausted, or reinstatement is actually denied.
4. Any portion of the cost of coverage which had been paid by the Covered Person prior to the leave must continue to be paid by the Covered Person during the leave. If the cost is raised or lowered during the leave, the Covered Person shall pay the new rates. If the leave is unpaid, the Covered Person and the Employer shall negotiate a reasonable means for paying the Covered Person's portion of the cost.
5. If the Employer provides a new health plan or benefits or changes the health benefits or Plan while the Covered Person is on leave, the Covered Person is entitled to the new or changed plan and benefits to the same extent as if the Covered Person were not on leave.
6. With respect to an FMLA leave, the Employer may recover its share of the cost of benefits paid during a period of unpaid leave if the Covered Person fails to return to work after the Covered Person's leave entitlement has been exhausted or expires, unless the reason the Covered Person does not return to work is

due to (i) the continuation, recurrence or onset of a serious health condition which would entitle the Covered Person to additional leave under the FMLA; or (ii) other circumstances beyond the Covered Person's control. If a Covered Person fails to return to work because of the continuation, recurrence or onset of a serious health condition, thereby precluding the Employer from recovering its share of the cost of benefits paid on the Covered Person's behalf during a period of unpaid leave, the Employer may require medical certification of the Covered Person's or the Covered Dependent's serious health condition. The Covered Person is required to provide medical certification within thirty (30) days from the date of the Employer's request. If the Employer requests medical certification and the Covered Person does not provide such certification in a timely manner, the Employer may recover the costs of benefits paid during the period of unpaid leave.

7. With respect to a VESSA leave, the Employer may recover its share of the cost of benefits paid during a period of unpaid leave if the Covered Person fails to return to work after the Covered Person's VESSA leave entitlement has been exhausted or expires, unless the reason the Covered Person does not return to work is due to (i) the continuation, recurrence or onset of domestic or sexual violence and would entitle the Covered Person to additional leave under VESSA; or (ii) other circumstances beyond the Covered Person's control. If a Covered Person fails to return to work because of the continuation, recurrence or onset of an act of domestic or sexual violence, thereby precluding the Employer from recovering its share of the cost of benefits paid on the Covered Person's behalf during a period of unpaid leave, the Employer may require certification of the Covered Person's inability to return to work for a reason described in (i) or (ii) above. The Covered Person is required to provide certification within thirty (30) days from the date of the Employer's request. If the Employer requests certification and the Covered Person does not provide such certification in a timely manner, the Employer may recover the costs of unpaid leave.
8. An FMLA leave and a VESSA leave shall run concurrently to the extent permitted by law.

ILLINOIS MUNICIPAL RETIREMENT FUND (IMRF) BENEFITS

The following Covered Persons and Covered Dependents will have the right to continue coverage at their own expense when an Employee's eligibility under this Plan ends:

1. a Full-Time Employee who is removed from the Employer's payroll due to retirement or disability, and who immediately becomes entitled to receive an IMRF pension or disability benefit;
2. the Covered Dependents of such a retired or disabled Employee who are covered under the Plan on the day before such Employee is removed from the Employer's payroll; and
3. the surviving spouse of such a retired or disabled Employee, but only if the spouse:
 - (a) is covered under the Plan on the day before such Employee's death;
 - (b) is eligible for IMRF benefits; and elects to receive an IMRF surviving spouse pension (rather than a lump sum death benefit).

Coverage under this Section may be continued until the earliest of:

1. the date the retired or disabled Employee:
 - (a) again becomes an active participant in IMRF;
 - (b) is convicted of an IMRF job-related felony; or

- (c) fails to pay any required contribution for coverage.
- 2. the date a disabled Employee is no longer entitled to IMRF benefit payments or takes a separation refund;
- 3. the date a spouse or child ceases to be an Eligible Dependent;
- 4. the date the surviving spouse:
 - (a) remarries prior to age fifty-five (55);
 - (b) dies; or
 - (c) fails to pay any required contribution for coverage, or
- 5. the date the Employer terminates medical coverage for all Employee.

Coverage for such retirees, disabled Employees and surviving spouses will be the same as for other Covered Persons and Covered Dependents and will be subject to any benefit changes or cost increases which take effect after the Employee is removed from the Employer's payroll. The retiree, disabled Employee or surviving spouse will be required to pay one-hundred percent (100%) of the cost of Plan coverage by each monthly due date.

Within fifteen (15) days after a Full-Time Employee retires, is removed from the Employer's payroll due to disability or dies, the Employer will:

- 1. verify the Employee's or surviving spouse's eligibility with IMRF for benefits; and
- 2. send the Employee or surviving spouse a notice of this continuation privilege (including the cost for continued Plan coverage).

For a disabled Employee, this continuation right will apply only if, after reviewing his or her medical information, the IMRF determines that IMRF disability benefits are payable. For a surviving spouse of a disabled Employee, this continuation right will apply only if the spouse elects a monthly annuity (rather than a lump-sum death benefit).

To continue Plan coverage, the retiree, disabled Employee or surviving spouse must send the Employer written election and first payment within thirty-one (31) days after receipt of the notice. In some cases the individual may sign a written authorization for IMRF to deduct future monthly payments for the cost of Plan coverage from his or her recurring IMRF benefit payments. Coverage provided pursuant to this Section will run concurrent with any other continuation coverage offered or available under the Plan.

MISCELLANEOUS

Non-alienation of Benefits

Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse or for any other relative of a Covered Person or Covered Dependent, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefit payable

hereunder, shall be void. The Plan shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

Invalid Provision

If any term or provision of this Plan or the application thereof to any person or circumstance shall, to any extent, be invalid or unenforceable, the remainder of this Plan, or the application of such term or provision to such persons or circumstances other than those as to which it is invalid or unenforceable, shall not be affected thereby, and each term and provision of this Plan shall be valid and shall be enforced to the fullest extent permitted by law.

Governing Law

The interpretation of the terms and provisions of this Plan shall be governed by the Laws of the State of Illinois where it has been executed, except where preempted by federal law.

Amendment/Termination

It is the intention of the Employer to maintain the Plan indefinitely. However, the Employer may amend or terminate the Plan at any time, provided that no such amendment or termination shall diminish or eliminate any Claim for any benefit to which a Covered Person or Covered Dependent shall have become entitled prior to such amendment or termination of the Plan.

Exclusive Benefit/Legal Enforceability

The Plan has been established and is being maintained for the exclusive benefit of the Employees of the Employer. The Plan terms, as provided herein, are legally enforceable by the Employees.

INTERPRETATION OF THE PLAN

Final authority for interpretation of the terms and provisions of the Plan is vested in the Employer. Any interpretation so required by the Employer shall be made in good faith, subject to reasonable care and prudence, and all such interpretations are final. The Employer shall have discretionary authority to determine eligibility for benefits and to construe the terms of the Plan.

DEFINITIONS

Active Service: A Covered Person will be considered in Active Service on a day which is a scheduled workday if he/she is performing in the customary manner all of the regular duties of his/her employment as a Full-Time Employee either at his/her customary place of employment or at some location at which that employment requires him/her to travel, or if he/she is absent from work solely by reason of vacation. A Covered Person will be considered in Active Service on a day which is not a scheduled workday only if he/she was performing in the customary manner all of the regular duties of his/her employment on the last preceding scheduled work day.

An Eligible Dependent will be considered in Active Service on any day if he/she is then engaging in all the normal activities of a person in good health of the same age and sex, and he/she is not confined in a medical facility. (This paragraph does not apply to a newborn child, nor does it apply to a child suffering from mental retardation or physical handicap solely by reason of such child's retardation or handicap.)

Ambulatory Surgical Facility: means any public or private establishment, which is either independent or part of a Hospital, with:

- (a) an organized medical staff of Physicians;
- (b) permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- (c) continuous Physician and Registered Nursing services whenever a patient is in the facility; and
- (d) no provision of services or other accommodations for patients to stay overnight.

Ambulatory Surgical Facility does not include an office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy.

Autism Spectrum Disorders: means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder and pervasive developmental disorder.

Birthing Center: means an entity licensed, approved or authorized to provide treatment for persons during uncomplicated pregnancy, routine full-term delivery and the immediate post-partum period. Such entity must:

- (a) provide skilled nursing care by or under the supervision of Registered Nurses;
- (b) be staffed and equipped to provide Emergency Treatment; and
- (c) have written back-up arrangements with a local Hospital to provide follow-up Emergency Treatment.

Change in Family Status: means any of the following events:

- (a) marriage or divorce of a Covered Person;
- (b) death of a Covered Person's spouse or dependent;
- (c) birth or adoption of a child by the Covered Person;
- (d) termination or commencement of employment of a Covered Person's spouse;
- (e) switching from part-time to full-time employment, or full-time to part-time employment by a Covered Person or spouse;
- (f) taking of unpaid leave of absence by a Covered Person or spouse; and
- (g) significant change in health coverage of a Covered Person's spouse attributable to the spouse's employment.

Claim: means a request for benefits under the Plan.

Claimant: means a Covered Person or Covered Dependent with a Claim for benefits under the Plan.

Covered Dependent: means an Eligible Dependent of any Covered Person for whom coverage became effective and has not terminated.

Covered Person: means an eligible Employee or former Employee whose coverage under the Plan became effective and has not terminated.

Creditable Coverage: means coverage of the Covered Person or Covered Dependent under any of the following:

- (a) a group health plan;
- (b) health insurance coverage;
- (c) Part A or B of Medicare;
- (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;
- (e) Chapter 55 of Title 10, United States Code;
- (f) a medical care program of the Indian Health Service or of a tribal organization;
- (g) a health plan offered under Chapter 89 of Title 5 of the United States Code;
- (h) a state health benefits risk pool;
- (i) a public health plan;
- (j) a health benefit plan under Section 5(e) of the Peace Corps Act;
- (k) Title XXI of the Social Security Act; or
- (l) a State Child Health Insurance Program (SCHIP).

Creditable Coverage shall not include coverage consisting solely of excepted benefits under the Health Insurance Portability and Accountability Act of 1996, including coverage solely for limited-scope dental or vision benefits.

Dental Services: means care and treatment of the teeth and gums, or any services rendered by a dentist or dental surgeon.

Diabetes Self-Management Training and Education: means instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalization and complications, and instruction in understanding nutrient needs relative to medically-prescribed diets, including tube feedings, specialized intravenous solutions, and specialized oral feedings, and food and prescription drug interactions. Diabetes Self-Management Training and Education shall include the content areas listed in the National Standards for Diabetes Self-Management Education Programs as published by the American Diabetes Association, including medical nutrition therapy.

Eligible Dependent: means an Employee's (or former Employee's):

- (a) spouse; or
- (b) unmarried child less than twenty-six (26) years of age, or less than thirty (30) years of age if a veteran and an Illinois resident who served in the Armed Forces of the United States and who has received a release or discharge other than a dishonorable discharge and who is chiefly Dependent upon the Employee for support and maintenance. (To be eligible for coverage, the eligible child who is a veteran shall submit to the Plan Administrator a form approved by the Illinois Department of Veterans' Affairs stating the date on which he/she was released from service.);

but excludes the following:

- (a) any person who is not a resident of the United States of America;
- (b) any person who is covered under this Plan as an Employee;

- (c) any person who is on active duty in any military, naval, or air force of any country; and
- (d) any spouse of an Employee who is legally separated from the Employee.

A child of the Employee includes a stepchild residing in the Employee's household in a normal parent-child relationship; an adopted child; a child in the custody of an Employee while adoption proceedings with respect to that child by the Employee are pending; or other child for whom the Employee has assumed a legal responsibility when such child is residing in the Employee's household in a normal parent-child relationship, but specifically excluding a foster child or grandchild (unless legally adopted).

At any time, the Employer or Contract Administrator may require proof that a child continues to qualify as an Eligible Dependent herein.

Emergency Treatment: means treatment required for accidental Injury or treatment of a sudden and unexpected Sickness which is life threatening or has such severe symptoms that the absence of immediate medical attention could result in serious and permanent medical consequences.

It shall not include treatment of symptoms of a chronic condition unless such symptoms are sudden, unexpected and severe.

Employee: means a person employed by Olympia Community Unit School District 16.

Employer: means Olympia Community Unit School District 16.

Expenses Incurred: means charges for purchases or services rendered. An expense will be deemed to be incurred on the day the purchase is made or on the day the service is rendered for which the charge is made.

Facility: means a medical Facility, other than a Physician's office, which lawfully performs tubal ligations.

Full-Time Employee: means a person who is scheduled to work at least thirty (30) hours per week (or such other requirement as set forth in any applicable collective bargaining agreement with the Employer) and who is on the regular payroll of the Employer and specifically excludes temporary, seasonal or part-time Employees.

Home Health Care Agency: means an organization, or its distinct part, which:

- (a) is primarily engaged in providing skilled nursing care and other therapeutic services for, and in the private residences of, persons recovering from Sickness or Injury;
- (b) qualifies as a Home Health Care Agency under Medicare and is licensed or approved according to any applicable state or local standards and is operated pursuant to policies established by a professional staff, including at least one (1) Physician and one (1) Registered Nurse;
- (c) provides full-time supervision of its services by a Physician or Registered Nurse and maintains clinical records on all of its patients;
- (d) has a full-time administrator; and
- (e) is not, other than incidentally, engaged in providing care or treatment of the mentally ill or in providing custodial-type care.

Home Health Care Plan: means a program of continued care and treatment for a Covered Person or Covered Dependent, established and approved in writing by the Physician of the Covered Person or Covered

Dependent. The program must be accompanied by the Physician's certification that the proper treatment of the Sickness or Injury would require confinement as a Hospital inpatient in the absence of the services and supplies provided as part of the Home Health Care Plan.

Hospice: means an entity licensed, approved or authorized to provide inpatient and at home medical relief of pain and supportive care to terminally ill persons. An inpatient facility must have on its premises:

- (a) organized facilities to care for and treat terminally ill persons; and
- (b) a paid staff of medical professionals to supervise such care and treatment.

Hospital: means an institution constituted and operated in accordance with the laws pertaining to Hospitals, equipped with permanent facilities for diagnosis, Surgery, twenty-four (24) hour continuous nursing service by Registered Nurses, and a staff of one or more Physicians licensed to practice medicine available at all times for compensation, and provides for medical and surgical treatment for Injury and Sickness on an inpatient basis. The term Hospital does not include a facility specializing in dentistry or an institution which is, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a convalescent home or a nursing home.

Hospital Confinement/Admission: means being registered as a bed patient in a Hospital upon the recommendation of a Physician, or as a patient in a Hospital because of a surgical operation, or as a patient receiving emergency care in a Hospital for an Injury.

Immediate Family: means a person's spouse and children.

Injury: means accidental bodily Injury of a Covered Person or Covered Dependent. All Injuries sustained by a Covered Person or Covered Dependent in connection with a single accident shall be considered one Injury.

Intensive Care Unit: means a section, ward or wing within the Hospital which is separated from other Hospital facilities and:

- (a) is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;
- (b) has special supplies and equipment, necessary for such care and treatment, available on a standby basis for immediate use; and
- (c) provides Room and Board and constant observation and care by Registered Nurses or other specially trained Hospital personnel.

Key Employee: means a salaried Employee eligible for leave under the Family and Medical Leave Act of 1993 who is among the highest paid ten percent (10%) of all the Employees employed by the Employer within seventy-five (75) miles of the Employee's worksite.

Licensed Practical Nurse: means an individual who has received specialized nursing training and practical nursing experience and who is licensed to perform nursing service by the state in which he or she performs such service, other than one who ordinarily resides in the patient's home or who is a member of the patient's Immediate Family.

Medically Necessary: means health care services, supplies or treatment which are appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

Mental Illness: means those illnesses classified as mental disorders in Section II of the edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association which is current as of the date services are rendered to a patient.

Necessary Services and Supplies: means any charge made by a Hospital on its own behalf for necessary medical services and supplies actually administered during any Hospital Confinement/Admission other than charges for Room and Board, Intensive Care Unit, private duty nursing or Physician's services.

Oral Surgery: means:

- (a) surgical removal of impacted teeth;
- (b) excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- (c) surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth, provided that the procedures are completed within six (6) months of the accident; and
- (d) excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts.

Outpatient Treatment: means treatment at a Hospital not requiring confinement and not involving a charge for Room and Board.

Physician: means a practitioner of the healing arts who is duly licensed in the state where he or she is practicing and who is treating within the scope and limitation of that license. The term Physician will not include the Covered Person, nor his or her spouse, children, brothers, sisters, parents or any other person residing in his or her household.

Plan Administrator: means Olympia Community Unit School District 16.

Plan Sponsor: means Olympia Community Unit School District 16.

Post-Service Claim: means any Claim for a benefit under the Plan that is not a Pre-Service Claim.

Pre-Existing Condition: means a condition for which a medical expenses were incurred or for which such person received medical care, treatment, consultation, diagnosis, diagnostic testing, advice, services, supplies or took prescribed drugs or medications, during the twelve (12) months month period ending on the Eligibility Date of such person's coverage under the Plan, or on the first day of a waiting period for coverage, if earlier. Genetic information is not a condition. A waiting period shall mean the period that must pass with respect to an individual before the individual is eligible for benefits under the Plan. Birth defects in an Eligible Dependent who is a child shall not be considered a Pre-Existing Condition.

Pre-Service Claim: means any Claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of receiving medical care.

Reasonable and Customary: means charges made for medical services and/or supplies essential to the care of an individual which are the amount normally charged by the provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the locality where the services or supplies are received for Sickness or Injury comparable in severity to the Sickness or Injury being treated.

Registered Nurse: means a professional nurse who has the right to use the title Registered Nurse (RN) other than one who ordinarily resides in the patient's home or who is a member of the patient's Immediate Family.

Room and Board: means all charges commonly made by a Hospital or other facility on its own behalf for room and meals and for all general services and activities essential to the care of registered bed patients.

Service Claim: means any Claim for a benefit under the Plan.

Sickness: means disease, mental, emotional or nervous disorders of a Covered Person or Covered Dependent. It also includes the pregnancy of a Covered Person or Covered Dependent.

Skilled Nursing Facility: means an institution, or a distinct part thereof, which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Sickness, and:

- (a) is approved by and is a participating Skilled Nursing Facility of Medicare;
- (b) has organized facilities for medical treatment and provides twenty-four (24) hour nursing service under the full-time supervision of a Physician or Registered Nurse;
- (c) maintains daily clinical records on each patient and has available the services of a Physician under an established agreement; and
- (d) has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one Physician.

This definition does not include an institution operated primarily for care of the aged, or for treatment of mental disease, drug addiction, alcoholism or custodial care.

Substance Abuse: means uncontrollable or excessive abuse of any addictive substance and the resultant physiological or psychological dependence which develops with continued use, requiring medical treatment as determined by a Physician.

Substance Abuse Treatment Facility: means a facility (other than a Hospital) whose primary function is the treatment of alcohol and Substance Abuse and which is duly licensed by the appropriate state and local authority to provide such services.

Surgery: means operative or cutting procedures including specialized instrumentations and the correction of fractures or complete dislocations.

OLYMPIA COMMUNITY UNIT SCHOOL DISTRICT 16

By: _____

Its: _____

Dated: _____

ADDENDUM A

PRESCRIPTION DRUG CARD PLAN

BENEFITS

FOR

EMPLOYEES OF

OLYMPIA COMMUNITY UNIT SCHOOL DISTRICT 16

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I. INTRODUCTION

The purpose of this Plan is to enable Eligible Persons to purchase Covered Drugs from a Pharmacy or through the HCH Administration, Inc. Mail-Order Program by paying only a portion (the Copayment Amount) of the full price of the particular drug. Covered Drugs are purchased from a Pharmacy by presenting to the Pharmacy both a Prescription Order (unless a refill) for the Covered Drugs and an Identification Card. Covered Drugs are obtained from the Mail-Order Program by completing the Registration & Prescription Order Form available from the Contract Administrator and mailing the form to CatalystRx. The Plan will be responsible for payment of all amounts in excess of the Copayment Amount. Without the Plan, Covered Drugs could only be purchased by paying full price, which in most cases would be more than the Copayment Amount.

II. ELIGIBILITY AND PLAN PARTICIPATION

1. Eligibility Requirements

You and your Dependents will be eligible to participate in the Plan when you and your Dependents have satisfied the eligibility requirements for benefits under the terms of the Health Plan.

2. Participation

You and your Dependents will begin participation on the first day on which you and your Dependents have met the eligibility requirements. When you become a Participant in the Plan, the Employer will issue you an Identification Card. You must present your Identification Card at the time you purchase Covered Drugs from a Pharmacy in order to take advantage of this Plan’s benefits.

III. DEFINITIONS

Code: means the Internal Revenue Code of 1986, as amended from time to time.

Copayment Amount: means the amount which an Eligible Person is required to pay for a Covered Drug in accordance with the Health Plan.

Covered Drug: means any Prescription Legend Drug and such other drugs as may be set forth from time to time in Exhibit 1 (attached hereto) and made a part of the Plan, when ordered by a Physician by means of a Prescription Order.

Dependent: means an individual who meets the definition of a Covered Dependent as set forth in the Health Plan.

Eligible Person: means an individual and/or his or her Dependents described in an Identification Card who are entitled to Covered Drug expense benefits in accordance with, and under the terms of, the Plan.

Employee: means a person employed by Olympia Community Unit School District 16.

Employer: means Olympia Community Unit School District 16.

Health Plan: Means the Olympia Community Unit School District 16 Health Benefit Plan.

Identification Card: means a card or cards issued as proof of eligibility for Covered Drug expense benefits in accordance with, and under the terms of, the Plan.

Participant: means an Employee or former Employee who has satisfied the Eligibility Requirements and has elected to participate in the Plan.

Pharmacy: means a pharmacy doing business as a licensed pharmacy under an applicable state license or registration number and which has entered into a Prescription Drug Agreement with CatalystRx.

Prescription Legend Drug: means any medicinal substance, the label of which is required by the Federal Food, Drug and Cosmetic Act to bear the legend – “Caution: Federal Law prohibits dispensing without prescription.”

Prescription Order: means a request for medication by a Physician.

Physician: means a doctor of medicine, a doctor of osteopathy, a doctor of dental Surgery, a doctor of dental medicine or a podiatrist, who is legally licensed to prescribe medications within the scope of that license. The term Physician shall also include a certified nurse practitioner, a licensed Physician’s Assistant and, in the case of outpatient mental health care, a licensed clinical psychologist.

IV. BENEFITS

Each Eligible Person may purchase Covered Drugs from a Pharmacy by presenting their Identification Card and paying the applicable Copayment Amount. Covered Drugs may be purchased from those Pharmacies listed on the Participating Pharmacy Listing, a copy of which may be reviewed at the location of the Contract Administrator or at such other sites as the Contract Administrator deems necessary. Pharmacies may be added to or deleted from the Participating Pharmacy Listing from time to time. Covered Drugs are obtained from the Mail-Order Program by completing the Registration & Prescription Order Form available from the Contract Administrator and mailing the form to CatalystRx.

V. PENALTIES FOR IMPROPER USE

Eligible Persons may not use their Identification Cards to obtain Covered Drugs after having received notification of the cancellation of their benefits or for persons other than Eligible Persons. Any Eligible Person who makes an improper use of his Identification Card may be guilty of a Class C misdemeanor in accordance

with the provisions of Section 512-8(c) of the Illinois Insurance Code and may be liable to the Administrator or Employer for amounts the Contract Administrator or Employer has paid as a result of any improper use of his Identification Card.

The Contract Administrator may request such amounts be paid immediately, and, if not paid when due, may take appropriate action to recover such amounts.

VI. CLAIMS

1. Filing a Claim

There may be certain instances in which an Eligible Person cannot use the Identification Card to receive prescription drug benefits from a Pharmacy. At those times, a Claim may be submitted in accordance with the Claim Provisions Section set forth in the Health Plan for consideration of Expenses Incurred that exceed the Copayment Amount. The Claim for prescription drug benefits must have the following information:

- (a) the name of the patient;
- (b) the Employee's name and social security number;
- (c) the name of the Pharmacy dispensing the drug;
- (d) the name, strength and quantity of the drug dispensed;
- (e) the date the drug was dispensed; and
- (f) the price of the drug.

2. Denial of Claims

If your Claim for benefits is denied, the Claim Provisions section of the Health Plan sets forth your rights regarding claims review procedures.

VII. GENERAL

1. Questions/Forms/Information

Any questions, requests for forms or other inquiries should be directed to the Contract Administrator or the Employer.

2. Nondiscrimination

It is the intent of the Employer that the Plan not discriminate in favor of any Employee or group of Employees. If the Employer determines that the Plan is discriminatory, the Employer shall select and exclude from coverage under the Plan such Participants, or reduce the contributions and/or benefits of such Participants, as shall be necessary to comply with the nondiscrimination provisions of the Code.

ADDENDUM B

SPECIAL TRANSPLANT POLICY

Notwithstanding anything in the Plan to the contrary, the Plan is hereby revised to include this special attachment regarding human organ and tissue transplant benefits as set forth in full in the Organ and Tissue Transplant Policy/Certificate (“Policy”). All Covered Persons and Covered Dependents requiring human organ and tissue transplant services will have transplant-related Expenses Incurred covered under this separate Policy, according to its terms and conditions from the time of the transplant evaluation through three-hundred sixty-five (365) days following the transplant operation (“Specified Benefit Period”). After this Specified Benefit Period has elapsed, coverage for all transplant-related medical benefits will revert to the terms and conditions of the Plan without reference to this addendum, except that benefits available under the Policy also apply toward the lifetime maximum of the Plan.

No benefits are available under the Plan for transplant-related services during the Specified Benefit Period except through the Policy or as specifically allowed below. Transplant-related benefits available during the Specified Benefit Period are subject to the terms and conditions of the Policy and only for Covered Persons and Covered Dependents to the extent they are not subject to a Pre-Existing Conditions waiting period under the Policy.

Covered Persons or Covered Dependents who are subject to a Pre-Existing Conditions waiting period under the Policy will be entitled to receive transplant benefits pursuant to the terms of the Plan until eligible for benefits under the terms of the Policy throughout the remainder of the applicable Specified Benefit Period. In addition, cornea human organ transplants will be covered in accordance with the terms of the Plan and not the Policy.

The Policy is issued by:

National Union Fire Insurance Company of Pittsburgh, PA
70 Pine Street
New York, NY 10270
(212) 770-7000

The Policy is fully-insured through the above referenced insurance company (“Issuer”) and benefits under the Policy are provided solely by the Issuer. The Issuer processes claims related to the Policy. Premiums due under the Policy are paid by the Employer.