WESTERN AREA SCHOOL
HEALTH BENEFIT PLAN

Effective Date: January 1, 2008

The Western Area School Health Benefit Plan is a self-funded health benefit plan established to provide medical benefits for employees of the following school districts, hereinafter known as the Western Area School Association Health Benefit Plan:

Abingdon Community Unit School District #217
Astoria Community Unit School District #1
Beardstown Community Unit School District #15
Community Unit School District #3 (Camp Point)
Community Unit School District #3, Fulton County (Cuba)
Community Unit School District #4 (Mendon)
Dallas Elementary School District #327
Hamilton Consolidated Unit School District #328
Havana Community Unit School District #126
Illini West High School District #307
La Harpe Community School District #347
Lewistown Community Unit School District #97
Liberty Community Unit School District #2
Mid-Illini Educational Cooperative
Midwest Central Community Unit School District #191
Payson Community Unit School District #1
Pikeland Community Unit School District #10
Pleasant Hill Community Unit School District #3
Regional Office of Education #22
Regional Office of Education #26
Regional Office of Education #27
Schuyler-Industry Community Unit School District #5
Southeastern Community Unit School District #337
Spoon River Valley Community Unit District #4
VIT Community Unit School District #2
Warsaw Community Unit School District #316
West Central Community Unit School District #235
West Central Illinois Special Education Cooperative (WCISEC)
West Prairie Community Unit School District #103
Western Area Career System #265

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Group # 799071
Original Effective Date with Third Party Administrator: July 1, 1999
Effective Date of this Document: January 1, 2008

HIPAA PRIVACY RULE

The information attached hereto is intended to bring the Western Area School Group Health Plan (hereinafter "GHP" or "Plan") into compliance with the requirements of § 164.504 (f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and § 164.504(f) is referred to as the "504" provisions") by establishing the extent to which the Plan Sponsor will receive, use and/or disclose Protected Health Information.

I. GHP's Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates the Plan Sponsor to take all actions required to be taken by the GHP in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts; accepting certification from the Plan Sponsor).

II. Definitions

All terms defined in the HIPAA Privacy Rule shall have the meaning set forth therein. The following additional definitions apply to the provisions set forth herein.

A. **Plan** (also referred to as "GHP") means the Western Area Schools Group Health Plan.
B. **Plan Documents** mean the GHP's governing documents and instruments (i.e., the documents under which the GHP was established and is maintained), including but not limited to the Western Area Schools Group Health Plan.
C. **Plan Sponsor** means Western Area Schools.

III. The GHP's Disclosure of Protected Health Information to the Plan Sponsor Required Certification of Compliance by Plan Sponsor

A. Except as provided below with respect to the GHP's disclosure of summary health information, the GHP will (a) disclose Protected Health Information to the Plan Sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor by the Third Party Administrator (TPA) with respect to the GHP, only if the GHP has received a certification (signed on behalf of the Plan Sponsor) that:

   1. The Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the "504" provisions;
   2. The Plan Documents have been amended to incorporate the Plan provisions set forth herein; and
   3. The Plan Sponsor agrees to comply with the Plan provisions as modified herein.

IV. Permitted Disclosure of Individuals' Protected Health Information to the Plan Sponsor

A. The GHP (and any business associate acting on behalf of the GHP), or TPA servicing the GHP, will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions contained herein.

B. All disclosures of the Protected Health Information of the GHP's individuals by the GHP's business associate or TPA to the Plan Sponsor will comply with the restrictions and requirements set forth herein and in the "504" provisions.

C. The GHP (and any business associate acting on behalf of the GHP), may not, and may not permit the TPA, to disclose individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

D. The Plan Sponsor will not use or further disclose individuals' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

E. The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the GHP (or from the GHP's TPA) agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

F. The Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

G. The Plan Sponsor will report to the GHP any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

HIPAA PRIVACY RULE (cont.)

V. Disclosure of Individuals' Protected Health Information – Disclosure by the Plan Sponsor

- **A.** The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. § 164.524.
- **B.** The Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. § 164.526.
- **C.** The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.
- **D.** The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individual's Protected Health Information received from the GHP available to the U.S. Department of Health and Human Services for purposes of determining compliance by the GHP with the HIPAA Privacy Rule when required.
- **E.** The Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the GHP (or TPA with respect to the GHP) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosure to those purposes that make the return or destruction of the information feasible.
- **F.** The Plan Sponsor will ensure that the required adequate separation, described in paragraph VII below, is established and maintained.

VI. Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor

- **A.** The GHP (or TPA with respect to the GHP), may disclose summary health information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions, if the Plan Sponsor requests the summary health information for the purpose of:

  1. Obtaining premium bids from health plans for providing health insurance coverage under the GHP; or
  2. Modifying, amending, or terminating the GHP.

B. The GHP or TPA with respect to the GHP, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

VII. Required Separation between the GHP and the Plan Sponsor

A. In accordance with "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may be given access to individuals' Protected Health Information received from the GHP or from the TPA servicing the GHP. It is the responsibility of the GHP to inform the TPA if any of the classes of employees or workforce members listed below should change.

1. Chairman of the Board
2. Secretary of the Board
3. Superintendents
4. Bookkeepers

B. This list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who receive individuals' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the GHP. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions contained herein.

C. The Plan Sponsor will promptly report any such breach, violation, or non-compliance to the GHP and will cooperate with the GHP to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effects of the violation or noncompliance.

HIPAA SECURITY STANDARDS

The section is intended to bring the Western Area School Association Employee Group Health Plan (hereinafter "Plan") into compliance with the requirements of 45 C.F.R. § 164.314 (b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing Plan Sponsor's obligations with respect to the security of Electronic Protected Health Information. The obligations set forth below are effective as stated herein.

I. Definitions

A. Electronic Protected Health Information – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

B. Plan – The term "Plan" means the Employee Group Health Plan as defined herein.

C. Plan Documents – The term "Plan Documents" means the group health plan's governing documents and instruments (*i.e.,* the documents under which the group health plan was established and maintained), including but not limited to this Group Health Plan Document.

D. Plan Sponsor – The Plan Sponsor is Western Area School Association.

E. Security Incidents – The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

II. Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

A. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

B. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

C. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

HIPAA SECURITY STANDARDS (cont.)

D. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

1. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
2. Plan Sponsor shall report to the Plan any other Security Incident as needed, or as requested by the Plan.

BENEFIT PLAN SUMMARY DESCRIPTION

1. NAME OF PLAN:
Western Area School Health Benefit Plan

2. NAME, ADDRESS & TELEPHONE NUMBER OF EMPLOYER (PLAN SPONSOR) AND AGENT FOR SERVICE OF PROCESS:
Western Area School Association
MidAmerica National Bank
P. O. Box 1300
130 N. Side Square
Macomb, Illinois 61455
(309) 833-4111

3. PLAN COORDINATOR:
Plan Sponsor

4. PLAN EMPLOYER IDENTIFICATION NUMBER:
Company Federal Identification Number: 37-1181316
Plan Number: 501-8491

5. TYPE OF WELFARE PLAN:
Major Medical Plan
Dental Plan
Prescription Drug Plan

6. TYPE OF ADMINISTRATION OF THE PLAN:
Contract Administration

7. NAME, ADDRESS & TELEPHONE NUMBER OF THIRD PARTY ADMINISTRATOR:
CCMSI Midland, LLC
PO Box 1430
Danville, Illinois 61834-1430
(800) 634-3506

8. NAME, ADDRESS & TELEPHONE NUMBER OF PLAN ADMINISTRATOR: *(The individuals titled below will be the sole Administrator of the Plan Sponsor responsible for initiating and signing Plan Amendments and Plan Documents):
Western Area School Association
MidAmerica National Bank
P. O. Box 1300
130 N. Side Square
Macomb, Illinois 61455
(309) 833-4111
*Chairman and Secretary

BENEFIT PLAN SUMMARY DESCRIPTION

9. NAME AND ADDRESS OF TRUST:
MidAmerica National Bank
P. O. Box 1300
130 N. Side Square
Macomb, Illinois 61455
(309) 833-4111

10. ORIGINAL PLAN EFFECTIVE DATE WITH THIRD PARTY ADMINISTRATOR: July 1, 1999
EFFECTIVE DATE OF THIS DOCUMENT: January 1, 2008

The Plan Sponsor has the right to amend this Plan Document. The Plan Sponsor will notify covered persons of such amendments to the Plan Document. Amendment contents will supersede the content of the Plan Document.

11. PLAN YEAR:
The books of the Plan are kept on an annual basis commencing on the Plan's effective date.

12. DESCRIPTION OF THE PLAN:
Plan benefits are described in this document, of which this "Benefit Plan Summary Description," is a part.

13. PROVISIONS FOR ELIGIBILITY REQUIREMENT (SUMMARY ONLY -- REFER TO THE ELIGIBILITY PROVISION OF THE PLAN DOCUMENT/PLAN BOOKLET FOR ADDITIONAL ELIGIBILITY INFORMATION):
All employees of participating districts regularly working at least 30 hours per week (or less if absent from work due to sickness, injury or approved leave of absence), excluding vacations and holidays, and who is on the permanent payroll of the employer, and their eligible dependents as defined. See the Eligibility section and the COBRA/Continuation of Benefits section for additional eligibility information.

14. CAUSES FOR INELIGIBILITY (SUMMARY ONLY -- REFER TO THE EFFECTIVE DATES AND TERMINATION DATES PROVISION OF THE PLAN DOCUMENT/PLAN BOOKLET FOR ADDITIONAL INELIGIBILITY INFORMATION):
Termination of the Plan.
Termination of employment, except as provided through COBRA/Continuation of Benefits.
Failure to make contributions, when required.
In addition, with respect to dependents, the cessation of dependent status as defined herein, except as provided through COBRA/Continuation of Benefits.

BENEFIT PLAN SUMMARY DESCRIPTION

15. ADDITIONAL PROVISIONS LIMITING BENEFITS (SUMMARY ONLY):
    Pre-existing conditions as defined herein.
    Maximum lifetime benefits.
    Exclusions and limitations, general, and applicable to benefits or types of services.
    Coordination with other benefit Plans.
    Subrogation.

16. SOURCES OF CONTRIBUTIONS TO THE PLAN:
    The Plan is self-funded by the respective school district, and is administered through the Western Area School Employee Benefits Trust, a trust established in accordance with Section 501(c) (9) of the Internal Revenue Code.

17. FUNDING MEDIUM:
    The Plan is self-funded from the employer and/or covered person's contributions. Benefit payments are made pursuant to the Plan provisions from the portion of these contributions which has been placed in the Benefit Trust Account. The Benefit Trust Account for this Plan is maintained in accordance with the provisions of the Administrative Services Agreement between the Plan Sponsor and the Third Party Administrator.

18. PROCEDURE FOR PRESENTING CLAIMS AND REDRESS OF DENIED CLAIMS:
    Detailed instructions for filing benefit requests and procedures for redress or appeal of a denied claim are included in this document.

MEDICAL SCHEDULE OF BENEFITS

Calendar Year Deductible per Person		Calendar Year Deductible maximum per Family		Calendar Year Out-of-Pocket* per Person		Calendar Year Out-of-Pocket* maximum per Family	
PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
$500		3 individuals		$2,000	$4,000	$6,000	$12,000
$1,000		3 individuals		$2,500	$5,000	$7,500	$15,000
$2,000		3 individuals		$3,500	$7,000	$10,500	$21,000
$3,000		3 individuals		$4,500	$9,000	$13,500	$27,000

*Includes Deductible.

Out-of-Pocket amounts for PPO and Non-PPO are a cumulative total until the PPO Out-of-Pocket amount has been reached. Any Non-PPO charges incurred after the cumulative PPO total has been reached will continue to be payable at the Non-PPO co-insurance until the Non-PPO Out-of-Pocket amount listed above is reached.

During the annual open enrollment period (August 15th through September 15th annually), individuals with existing coverage and late entrants with coverage, will have the opportunity to purchase one of the plans as stated above. This change will go into effect on October 1st of the same year. New hires with coverage or special enrollees with coverage will also have the opportunity to choose one of the plans as stated above at the time of enrollment; however, such individuals will not be able to change Plans until the annual open enrollment period.

There will be an additional period of time that individuals with coverage can change their deductible level. This time period is during the month of December with any resultant change in coverage becoming effective on January 1st of the next year.

FIRST DOLLAR BENEFITS The benefits in the Section below are payable at 100%. These benefits do not apply towards the calendar year deductible.	**(LIMITS, IF ANY)**
Second Surgical Opinion (and Third Surgical Opinions, when necessary)	
Pre-admission Testing	Within seven (7) days of hospital admission
Mammograms	One (1) baseline mammogram for each covered person prior to age 40 One (1) mammogram per calendar year for covered persons age 40 and over

MEDICAL SCHEDULE OF BENEFITS (cont.)

FIRST DOLLAR BENEFITS (cont.)	LIMITS (IF ANY)
Routine Pap Smears including associated doctor's office visit and laboratory charges directly associated with routine pap smear	One (1) exam per calendar year
Routine Proctoscopy including associated doctor's office visit and laboratory charges directly associated with routine proctoscopy	One (1) exam per calendar year
Annual Digital Rectal Examination including associated doctor's office visit and laboratory charges directly associated with digital rectal examination	One (1) exam per calendar year
Routine Prostatic Specific Antigen ("PSA") Test including associated doctor's office visit and laboratory charges directly associated with routine PSA	One (1) exam per calendar year

MAJOR MEDICAL BENEFITS: The benefits in the section below are payable at the applicable PPO/Non-PPO co-insurance rate (unless otherwise stated) and are subject to the calendar year deductible (unless otherwise stated). The Plan will pay eligible charges in excess of the calendar year deductible (if applicable) incurred at or by a PPO Provider at 80%, and the Plan will pay eligible charges in excess of the calendar year deductible (if applicable) incurred at or by a Non-PPO Provider at 70%. Any limitations stated are for PPO and Non-PPO services combined.

BENEFITS/ADDITIONAL MAXIMUMS	CO-INSURANCE/ LIMITS (if any) Deductible applies unless otherwise stated	
	PPO	Non-PPO
Well Child Care from birth to age one (1) – including office visits, labs, and immunizations directly associated with the wellness care.	80%	70%
Outpatient Surgery and associated x-ray and laboratory supplies (when performed on the same day as the surgery) when performed in an ambulatory surgery facility, outpatient facility of a hospital, or a physician's office.	90%	70%
Extended Care/Skilled Nursing Facility (Care must begin within 14 days of hospital confinement of at least three (3) consecutive days)	50% co-insurance	
Home Health Care	40 days per calendar year	
Inpatient *Mental and Nervous Disorders and *Substance Abuse (Treatment incurred for substance abuse is subject to the Lifetime Maximum stated below)	Limited to two (2) inpatient stays per lifetime up to 60 days per stay for mental and nervous disorders and substance abuse combined	

*Charges incurred for inpatient and outpatient mental and nervous disorders and substance abuse do not apply towards the out-of-pocket and will never increase to 100%.

MEDICAL SCHEDULE OF BENEFITS (cont.)

Major Medical Benefits (cont.)

BENEFITS/ADDITIONAL MAXIMUMS	CO-INSURANCE/LIMITS (if any) Deductible applies unless otherwise stated	
	PPO	Non-PPO
Outpatient *Mental and Nervous Disorders and *Substance Abuse (Treatment incurred for substance abuse is subject to the Lifetime Maximum stated below)	80% co-insurance – Limited to 50 visits per calendar year for mental and nervous disorders and substance abuse combined	
Lifetime maximum benefit payable for inpatient and outpatient Substance Abuse combined	$25,000	
Emergency room visits (co-payment continues to apply after the out-of-pocket maximum is met)	$150 co-payment per visit	
Chiropractic care	Limited to $1,000 payable per calendar year	
<u>Transplant Procedures:</u> Maximum benefit payable for:		
Expenses incurred for organ procurement from a non-living donor	$10,000	
Expenses incurred for organ procurement from a living donor per donor's lifetime	$25,000	
Expenses incurred for transportation, lodging, and meals combined cannot exceed $200 per day and $10,000 per transplant (For one (1) adult or two (2) adults if the covered recipient/donor is a minor)		
Overall Transplant Procedure per recipient's lifetime	$1,000,000	
All other covered expenses	80%	70%
Lifetime maximum benefit payable for all covered charges combined while covered	$2,000,000	

*Charges incurred for inpatient and outpatient mental and nervous disorders and substance abuse do not apply towards the out-of-pocket and will never increase to 100%.

NOTE: The Plan has a mandatory Pre-certification Program for Hospital Admission. When **ANY** hospital admission is proposed, Midland Management UR Services (MMURS) must be called. Failure to follow the procedures and recommendations of the Utilization Review program will result in the application of an additional $250 deductible per occurrence or the lesser of the actual benefit. Penalties applied due to failure to comply with the procedures and recommendations of the Utilization Review Program will not apply towards the out-of-pocket and will never increase to 100%. In the case of an emergency, MMURS must be notified by phone of the emergency admission or surgical procedure within 48 hours of the hospital admission or surgery.

MEDICAL SCHEDULE OF BENEFITS (cont.)

NOTE: The OSF Holy Family facilities located in Monmouth, Illinois will be considered a Preferred Provider under this Plan. This is to include:

OSF Holy Family Medical Center, located in Monmouth, Illinois
OSF Holy Family Clinics, located in Monmouth, Illinois
OSF Holy Family Home Health, located in Monmouth, Illinois

NOTE: The following listing of exceptions represents services, supplies or treatment rendered by a Non-PPO provider where covered charges shall be payable at the PPO level or benefits:

A. Emergency treatment rendered at a Non-PPO facility (this includes the ER physician charges). If the covered person is admitted to the hospital after such emergency treatment, covered expenses shall be payable at the PPO level. Follow-up care after discharge from the hospital will be payable at the applicable PPO/Non-PPO level of benefits.
B. Non-PPO anesthesiologist if the operating surgeon or hospital is PPO.
C. Radiologist or pathologist services for interpretation of x-ray and laboratory tests rendered by a Non-PPO provider when the facility rendering such services is a PPO provider.
D. While confined to a PPO hospital, the PPO physician requests a consultation from a Non-PPO provider.
E. While obtaining services in a PPO facility, the PPO physician requests assistance from a Non-PPO provider, for example, assistant surgeon services.

DENTAL SCHEDULE OF BENEFITS

DENTAL EXPENSE BENEFITS	
Calendar year deductible per person	$50
Calendar year deductible maximum per family	Two (2) individual deductibles
Calendar year maximum benefit payable per person (subject to the family maximum)	$500
Calendar year maximum benefit payable per family (subject to the individual maximum)	$1,000
CLASS OF BENEFITS	**CO-INSURANCE**
Class I – Preventive Care	100% no deductible
Class II – Basic Care	80% after deductible
Class III – Major Care	50% after deductible
Benefits are not available for orthodontia care	

Please refer to the Dental Benefits section for a further description of Dental Benefits.

NOTE: Dental benefits are available for only those employees (and any eligible dependents) that are employed by a School District that has chosen to offer Dental Benefits. Each School District will have the opportunity to elect or decline Dental Benefits on a yearly basis. The Dental Benefits period will begin annually on October 1st.

NOTE: Employees have the right to choose the level of coverage i.e. Single, Family or none. An employee can choose Single Medical and choose Family Dental, or can have Family Medical and Single Dental. Dental is not an option unless the employee also participates in the medical coverage.

PRESCRIPTION DRUG PROGRAM

PREFERRED FORMULARY PROGRAM	CO-PAYMENT
Retail Drug Program: (Up to a 34-day supply of a covered prescription drug)	
Generic Drugs	$15.00
Brand Preferred Formulary	$30.00
Brand Non-Preferred	$40.00
Mail-Away Drug Program: (Up to a 90-day supply of a covered prescription drug)	
Generic Drugs	$25.00
Brand Preferred Formulary	$50.00
Brand Non-Preferred	$70.00
• The Generic co-pay will apply when a generic drug is requested • The Brand Preferred Formulary co-pay will apply when a brand-name drug, on the Preferred Formulary List, is requested. • The Brand Non-Preferred co-pay will apply when a brand-name drug, not on the Preferred Formulary List, is requested.	

Contact Express Scripts at 800-524-4491 or visit their website at www.express-scripts.com to obtain information about the new preferred formulary drug program and to get information about obtaining your prescriptions at the most cost effective co-pay.

NOTE: Eligible Prescription Drugs must be purchased by use of the Express Scripts Retail Drug Card Program or the Express Scripts/Value RX – Mail-Away Drug Program. The Plan will not reimburse drugs purchased without use of the Prescription Drug Card or through the Mail-Away Program. However, diabetic supplies, blood glucose meters and insulin can be purchased through the Drug Card or Mail-Away program or they can be purchased without the use of this program and submitted as a medical expense.

EXPRESS SCRIPTS - RETAIL DRUG CARD PROGRAM

Prescriptions can be filled by use of the Express Scripts Retail Network Service, which allows you to get up to a 34-day supply of a Prescription Drug filled at any Network Pharmacy. You present your Drug Card and pay the co-payment as stated in the Schedule of Benefits. Your Employer has a list of participating Network Pharmacies, or you can call (800) 524-4491 for additional participating Network Pharmacy information.

EXPRESS SCRIPTS/VALUE RX- MAIL-AWAY DRUG PROGRAM

If you have a prescription for a maximum of a 90-day supply of a prescription drug, you can utilize the Mail Service Program through Express Scripts/Value Rx.

Benefits are payable, as stated in the Schedule of Benefits, when a person incurs expenses for a prescribed drug ordered through Express Scripts/Value Rx. You can call (between the hours of 8 a.m. and 12 midnight EST) at (800) 524-4491 with mail-away questions.

COVERED DRUGS

1. Prescription Legend Drugs unless otherwise stated herein;
2. Retin-A (tretinoin) when used for acne treatment or subsequent FDA approved indications other than for cosmetic purposes, which will not be covered.
3. Retrovir, or other similar drug classifications.
4. Birth control pills through the Retail Drug Plan. All other means of prescribed birth control prevention, including but not limited to injections and Norplant implants, will be payable under the Major Medical Plan.

EXCLUSIONS AND LIMITATIONS

The following are excluded:

1. Prescribed vitamins, however prescribed prenatal vitamins are covered;
2. Drugs, implants, injectables or devices prescribed for birth control, weight control, or smoking control. (All means of birth control, EXCEPT the *birth control pill, are excluded. However, if prescribed due to medical necessity, other means of birth control will be covered.) *Birth control pills are covered through the Retail Drug Plan. All other means of prescribed birth control prevention, including but not limited to injections and Norplant implants, will be payable under the Major Medical Plan.
3. The administration of prescription drugs or administration of injectable insulin;
4. Cosmetic drugs (i.e., Rogaine, Retin-A (except as stated above));
5. Fertility drugs;
6. Injectable drugs;
7. Any drug or medication that is not a covered drug;
8. Any covered drug prescribed for use by other than a covered employee or covered dependent;
9. The amount of any covered drug prescription or refill in excess of a 34-day supply (for the Retail Card Program) or a 90-day supply (for the Mail-Away Program) according to the directions, or in excess of 100 tablets or capsules, whichever is greater;
10. Any prescription refill of a covered drug in excess of the number specified by the physician, or which is dispensed more than one (1) year after the date the prescription was written;
11. Any covered drug which may be received without charge under any local, state or federal government program; or
12. Any covered drug that is prescribed for sickness or injury that would entitle the covered individual to benefits provided under Workers' Compensation Act or similar legislation.

CLAIM FILING INFORMATION

When covered expenses are incurred, covered persons must submit one (1) claim form per year. Additional claim forms may be required by the Third Party Administrator.

Send Medical Claims to:
CCMSI Midland, LLC / HL
P.O. Box 419104
St. Louis, Missouri 63141-9104
Electronic Claim Submission
EDI Vendor #90001
EDI Clearinghouses: Envoy, Web/MD

Send Dental Claims and All Questions to:
CCMSI Midland, LLC / 799071
P.O. Box 1430
Danville, IL 61834-1430
Electronic Claim Submission
EDI Payer ID #37105
(800) 634-3506

Your Group No: 799071

Preferred Provider Organization (PPO):

For PPO information and PPO Providers, call HealthLink, Inc. at (800) 624-2356 or (314) 989-6300. On the web, www.healthlink.com. Provider directories are available without charge.

Utilization Review and Pre-certification of Hospital admissions:

For pre-certification of hospital admissions, call Midland Management UR Services (MMURS) at (888) 227-8904.

Prescription Drug Services:

Express Scripts is the Pharmacy Benefit Manager. For prescription member service questions, call (800) 451-6245. Call (800) 235-4357 for the Pharmacy Help Desk.

Please see the General Provisions section, Notice and Proof of Claims provision, for further claim filing details.

INTRODUCTION

The Plan Sponsor has retained the services of an independent Third Party Administrator experienced in processing benefits to handle health benefit requests.

If the covered person incurs expenses for which they wish to request benefits, itemized bills that adequately describe all services rendered must be submitted as stated in the Claim Filing Information section and completed within the time frames stated in the Notice and Proof of Claims provision in the General Provisions section.

This Plan Document/Plan Booklet contains descriptions of coverage provided under the Plan. It should be understood that this Document contains terms, conditions and provisions of the Plan. A copy of this Document is to be kept on file with the Plan Sponsor and with the Third Party Administrator.

PLAN DOCUMENT

Whereas the Plan Sponsor desires to establish a plan to provide health and certain other benefits for employees, it does, therefore, create and establish the Western Area School Health Benefit Plan herein after referred to as the "Plan" and this Document herein after referred to as the "Plan Document".

PURPOSE

The purpose of this Plan is to set forth the provisions of the Plan which provide for the payment or reimbursement for all, or a portion of, covered medical expenses.

PLAN AMENDMENTS

The Plan Document shall be the sole Document used in determining benefits to which covered persons are eligible and may be amended from time to time by the Plan Sponsor to reflect changes in benefits or eligibility requirements. Such Amendment must be initiated and approved by the Administrator named or titled in the Schedule of Benefits. Any changes so made shall be binding (with or without notice) on each individual covered and on any other individual or individuals (including COBRA Participants, Alternate Recipients, and covered persons out on Family Medical Leave) referred to in this Plan Document. The Plan is not in lieu of, and does not affect, any requirements for coverage by Workers' Compensation.

Wherever used in this Plan, masculine pronouns shall include both masculine and feminine gender unless the context indicates otherwise.

UTILIZATION REVIEW

The Plan has a mandatory Pre-certification Program for Hospital Admission. When **ANY** hospital admission is proposed, Midland Management UR Services (MMURS) must be called. Failure to call or failure to follow the procedures and recommendations of MMURS will result in the application of an additional $250 penalty deductible per occurrence or the lesser of the actual benefit. Penalties applied due to failure to comply with the procedures and recommendations of the Utilization Review Program will not apply to the out-of-pocket and will never increase to 100%.

The telephone number for pre-certification is:
Midland Management UR Services 1-888-227-8904.

HOSPITAL PRE-ADMISSION REVIEW

INITIATING PRE-ADMISSION REVIEW

1. Pre-admission Review and Admission Review can be initiated by simply phoning MMURS toll-free 888-telephone number.
2. The patient, hospital, attending physician or physician representative is required to call MMURS at least five (5) working days prior to a non-emergency (elective) admission.
3. When an emergency admission occurs, any of the above parties are required to call MMURS within 48 hours of hospital admission.

PRE-ADMISSION CERTIFICATION

Pre-Admission Review requests will be reviewed initially by a MMURS RN utilizing Severity of Illness/Intensity of Service Screening Criteria.

1. The RN will obtain the medical information necessary to conduct the review from the hospital and physician.
2. The RN will compare the furnished medical information with the screening criteria. The process includes a review to determine if:
   (a) The procedure is appropriate to outpatient performance;
   (b) The diagnosis/problem is appropriate to outpatient treatment; and
   (c) The proposed procedure requires a pre-surgical review.
3. If the admission criteria are met, the RN will:
   (a) Certify the medical necessity of the admission;
   (b) Assign the appropriate initial Length of Stay: The Length of Stay assignment takes into consideration the patient's age, single versus multiple diagnoses and surgical versus non-surgical hospitalizations. The Length of Stay norms are based on national average days of care statistics. The length of stay norms are divided by both diagnoses and procedures;

   (c) Provide the attending physician and patient with verbal notification within one (1) working day of the review determination if the admission is scheduled to occur in less than one (1) day from the time of review;
   (d) Issue a written notice to the attending physician, patient and Third Party Administrator. Notice may also be provided to the hospital;
   (e) Schedule the next continued stay review.
4. If admission criteria are not met, the RN will contact the attending physician.
5. If the additional information from the attending physician does not meet the admission criteria, the RN will refer the furnished information to the Medical Director for review.
6. The Medical Director will review the information submitted by the attending physician and will make a determination on the medical necessity and appropriateness of the hospitalization.
7. If the Medical Director has questions after reviewing the information, the attending physician will be contacted and given an opportunity to respond.
8. The medical basis for the Medical Director's decision, and the name of the Medical Director who made the decision, will be documented on the utilization review worksheet.

EMERGENCY ADMISSION PROCEDURES

1. Cases admitted on an emergency basis will not require review prior to admission.
2. The hospital, physician, or patient will be required to notify MMURS by phone of emergency admissions within 48 hours of the admission.
3. The patient, hospital, attending physician and Third Party Administrator will receive written notification of the review determination and the length of stay recommended for the admission.
4. Confirmed emergency admissions will be recorded as such for the purpose of program monitoring.
5. Medically necessary admissions that are <u>not confirmed as an emergency</u> will be subject to the following:
   (a) MMURS's review determination will properly classify the admission as elective or urgent;
   (b) Significant patterns of cases inappropriately classified as emergencies will be referred to the appropriate MMURS committee for further evaluation and intervention.
6. Emergency admissions that are not confirmed and found to be medically unnecessary or inappropriate will not be recommended for medical necessity certification. Notices of the determination will be issued to the patient, attending physician, hospital and Third Party Administrator no later than the first working day after reviewing the patient's admission information.

HOSPITAL CONTINUED STAY REVIEW AND DISCHARGE ASSISTANCE

MMURS's Pre-admission and Admission Review Program includes a Length of Stay assignment. The notice provided to the hospital, physician and patient states that any additional days of hospital care must be approved by MMURS. The attending physician, patient or family member may contact MMURS to obtain approval for additional days when it appears that a patient's hospital stay will exceed the number of approved inpatient care days. Even when MMURS is not notified of the need for additional days, a follow-up continued stay review will be automatically conducted by MMURS's RN to determine if the patient's continued stay is medically necessary and appropriate. The Continued Stay Review Program will be conducted for all admissions subject to Pre-admission Review.

MMURS INITIATED CONCURRENT REVIEW PROCESS

1. On the last certified day, the RN will contact the hospital to determine if the patient is still hospitalized.
2. If the patient is still hospitalized, the RN will contact the hospital to:
   (a) Remind the attending physician that the patient's certification ends on the specified date.
   (b) Determine whether the patient will be discharged.
   (c) Determine if the patient's condition requires additional inpatient care days, discharge planning assistance or large case management.
3. The patient, attending physician, and Third Party Administrator will be notified in writing of the re-certification determination.
4. When continued hospital stay is approved, the re-certification notice will include a new Length of Stay assignment.
5. The continued stay review and re-certification process will continue until the patient is discharged or continued certification is not recommended as medically necessary or appropriate.

NON-CERTIFICATION AND APPEAL PROCESS AND RIGHTS

NON-CERTIFICATION

1. The RN will refer all cases not meeting admission or continued stay criteria to the Medical Director for review.
2. If the Medical Director has questions after reviewing the information, the attending physician will be contacted and given an opportunity to discuss the case.
3. The Medical Director will advise the attending physician of the review determination. All review determinations will be based on the medical necessity and appropriateness of the patient's hospitalization.
4. A Non-Certification will be issued whenever there is a Medical Director determination that the admission, length of stay or service under review is not appropriate, or does not require acute level hospital care.
5. Written notification of Non-Certifications will be distributed on the day that a Medical Director's decision or consensus is reached.

6. Non-Certifications will be distributed to the patient, attending physician, hospital and Third Party Administrator.
7. The medical basis for the Medical Director's decision, and the name of the Medical Director who made the decision, will be documented.
8. A copy of the Non-Certification will be retained on file.
9. It will be the responsibility of the attending physician or the hospital to request another review if, after a Non-Certification is issued, the patient's condition changes such that acute level care is required.
10. Non-Certification notices will include a statement informing all parties of their right to a reconsideration of the adverse determination.

APPEAL PROCESS AND RIGHTS

Definitions:

Appeal: A request made by the patient, patient representative, provider or facility to have the non-certified case reviewed again by a different physician (in the same or similar specialty as the treating physician) who was not involved in the initial non-certification determination.

Non-Certification: A determination not to certify proposed or ongoing treatment as medically necessary when established guidelines have not been met. The Non-Certification notice is provided on behalf of the Plan Sponsor in compliance with the Department of Labor Regulation 29 CFR Part 2560.

Appeal Process:

When a Non-Certification is issued, each patient is entitled to the following appeals process:

Level I Expedited Appeal

Level I Expedited Appeals are available only when the patient remains in active (imminent and ongoing) treatment, or urgent care is needed. The patient or patient representative may request this type of appeal either verbally or in writing. The appeal determination will be completed within one (1) business day of the request. Level I Expedited Appeals are completed by a physician in the same or similar specialty as the treating physician, who was not previously involved in the case.

Level II Standard Appeal

Level II Standard Appeals can result from (1) an expedited appeal that did not reverse the initial decision not to certify; or (2) Non-Certification based on lack of medical necessity from a pre-certification or retrospective review. The patient or patient representative may request this appeal either verbally or in writing within 180 days of the date of the non-certification letter. Level II Standard Appeals are completed by a physician in the same or similar specialty as the treating physician, who was not previously involved in the case.

Level III Final Appeal

Level III Final Appeals are available when a Level II Standard Appeal does not result in a reversal of the initial non-certification. The patient or patient representative may request a Level III Final Appeal within 180 days of Level II Standard Appeal determination. Level III Final Appeals are completed by a physician in the same or similar specialty as the treating physician, who was not previously involved in the case.

Timeframes:

Level I Expedited Appeal: The request for a Level I Expedited Appeal must be made within 180 days following receipt of non-certification. The Level I Expedited Appeal determination will be completed in one (1) business day.

Level II Standard Appeal: The request for a Level II Standard Appeal must be made within 180 days following receipt of Non-Certification. The Level II Standard Appeal determination will be completed no later than 15 calendar days of receipt of request.

Level III Final Appeal: The request for a Level III Final Appeal must be made within 180 days following receipt of Level II Standard Appeal determination. The Level III Final Appeal determination will be completed no later than 15 calendar days of receipt of request.

Appeal Rights:

Covered persons are entitled to receive upon request, and free of charge:

1. Copies of all documents, records and other information relevant to request for certification of care;
2. A copy of the rule, guideline or protocol used in making the non-certification decision;
3. A copy of the portion of the Plan Document that was used in determining medical necessity.

MAJOR MEDICAL BENEFITS

DEDUCTIBLE: The deductible as stated in the Schedule of Benefits applies per calendar year to each covered person.

FAMILY DEDUCTIBLE: In the event the deductible requirement is satisfied with respect to 3 covered family members during a calendar year, the deductible amount shall be deemed to be satisfied for the remainder of that calendar year for all covered family members.

DEDUCTIBLE CARRYOVER: Any amount applied toward the deductible by charges incurred on or after October 1st, will go toward the satisfaction of the next calendar year deductible.

DEDUCTIBLE FOR A COMMON ACCIDENT: If two (2) or more covered family members are injured in the same accident, only one (1) major medical deductible will be applied each year against all the expenses incurred as a result of such accident.

CO-INSURANCE: After satisfaction of the calendar year deductible (if applicable), the Plan will pay the applicable PPO/Non-PPO co-insurance rate as stated in the Schedule of Benefits, unless otherwise stated. Once the out-of-pocket amount as stated has been satisfied, remaining eligible expenses for the calendar year are payable at 100% unless otherwise indicated.

OUT-OF-POCKET: Once the out-of-pocket (including deductible) as stated in the Schedule of Benefits has been accrued by a covered person, then 100% of excess covered medical expenses will be payable during the rest of that calendar year. The maximum out-of-pocket per family is stated in the Schedule of Benefits. Charges incurred for mental and nervous disorders, substance abuse, and deductibles applied due to failure to comply with the procedures and recommendations of the Utilization Review Program do not apply towards the out-of-pocket amount as stated herein and charges incurred will never increase to 100%.

LIFETIME MAXIMUM WHILE COVERED: The overall lifetime maximum benefit while covered under this Plan per covered person is stated in the Schedule of Benefits.

COVERED MEDICAL EXPENSES

Covered medical expenses include reasonable and customary expenses prescribed by a physician incurred for the services and supplies listed below provided for or in connection with medically necessary treatment of the sickness or injury. Some exclusions may apply to these covered medical expenses. Please also read the Exclusions and Limitations provision of the Plan Document/Plan Booklet.

Hospital room and board including bed and board, general nursing care, meals and dietary services provided by the hospital. All semi-private rooms, or ward accommodations, are covered subject to the limitations stated herein.

For private rooms, an allowance will be paid equal to the hospital's semi-private room charge for the unit in which the covered person resides.

If the hospital only has private room facilities, private room charges will be considered as semi-private charges.

If a private room is medically necessary for isolation purposes, the private room charge will be considered as a semi-private room.

For Intensive Care, Coronary Care and Intermediate Units, all necessary charges are covered the same as an illness.

Miscellaneous hospital services including equipment, medications and supplies.

Hospital charges for covered outpatient services.

When two (2) or more surgical procedures are performed at one (1) time through the same incision or in the same operative field, the maximum amount allowable for the surgery will be the reasonable and customary charge for the major procedure and 50% of the reasonable and customary charge for the secondary or lesser procedure(s).

Anesthetics and their administration.

Surgical Assistant charges valued at no more than 25% of the reasonable and customary amount allowed the Principal Surgeon.

Physician's services for medical care and treatment.

X-ray and laboratory examinations made for diagnostic or treatment purposes.

Routine Pap Smears including related services performed by a physician in a physician’s office, limited to one (1) routine pap smear per person per calendar year.

COVERED MEDICAL EXPENSES (cont.)

Routine annual Digital Rectal Examination including related services performed by a physician in a physician's office, limited to one (1) examination per person per calendar year.

Routine Proctoscopy including related services performed by a physician in a physician's office, limited to one (1) routine proctoscopy per person per calendar year.

Routine Prostatic Specific Antigen (PSA) including tests and related services if performed by a physician in a physician's office limited to one (1) routine PSA per person per calendar year.

Well Child Care after discharge from the hospital is covered up to age one (1). This is to include office visits, labs, and immunizations directly associated with the wellness care.

MEDICAL SUPPLIES:

1. When benefits for prescription drugs are provided under the prescription drug service program of the plan, charges for prescription drugs under the Covered Medical Expenses section of the Plan are limited to charges made by a hospital or medical treatment facility for prescription drugs administered to a covered person while in such hospital or medical treatment facility.
2. Medical supplies necessary to check, maintain and regulate blood glucose levels including, but not limited to, the following items: Insulin, glucose monitors, needles and syringes and test strips.
3. Surgical supplies, sutures, casts, splints, trusses, braces, crutches or other medical supplies with the exception of dental braces or corrective shoes.
4. Oxygen and rental of equipment for its administration.
5. Rental (up to the purchase price) of durable medical equipment, including (but not limited to) wheelchair or hospital-type bed, iron lung or other respiratory paralysis equipment, or kidney dialysis equipment. These items may be purchased rather than rented, if the ongoing rental of the item will exceed the purchase price. Maintenance (or maintenance agreements) of durable medical equipment is not an eligible expense under this Plan.
6. Artificial limb(s) or eye(s) and initial purchase of prosthetic appliances (limited to one appliance) unless there is a new prescription due to growth, wear and tear, or accidental bodily injury which necessitates replacement of such prosthetic appliance.
7. Blood (if not replaced) and blood derivatives.
8. Anesthesia.
9. Heart pacemaker or other similar heart implantable devices.

Charges for regularly scheduled commercial transportation by train or plane within the continental United States and Canada to a hospital that has medical equipment not available locally for specialized treatment. Such transportation must be certified by the acting physician as necessary due to its emergency nature. This transportation is limited to one (1) round trip per accident or sickness.

COVERED MEDICAL EXPENSES (cont.)

Charges for necessary local ambulance transportation to the nearest hospital or medical institution where necessary care and treatment of the injury or sickness can be given.

Physical Therapy by a Registered Physical Therapist.

Occupational Therapy by a Registered Occupational Therapist.

Chemotherapy, Radiation Therapy by x-ray, radon, radium and radioactive isotopes.

Allergy shots and allergy surveys.

Mammogram expenses up to the maximum stated in the Schedule of Benefits.

Charges for professional services or for services of a Registered Professional Nurse or a Licensed Practical Nurse.

Dental services rendered by a physician or dentist for the treatment of an injury to the jaw or to sound natural teeth, including the initial replacement of these teeth and any necessary dental x-rays resulting from an accident occurring while covered, provided the treatment is rendered within six (6) months of the accident.

Extended Care/Skilled Nursing Facility charges for daily room and board, general nursing services, and supplies made by such Extended Care/Skilled Nursing Facility for each day of covered Extended Care/Skilled Nursing Facility confinement, up to the limitations stated herein.

Hospice Care charges as stated herein.

Inoculations when recommended by a physician because of exposure to a contagious disease.

Charges incurred for elective sterilizations.

Charges for the first pair of glasses or contact lenses, but not both, needed after cataract surgery. This does not include lens tinting or scratch resistant lenses or other types of additional lens services that may be offered (unless medically necessary).

Charges for human organ, tissue transplants and bone marrow transplants if approved by the United States Food and Drug Administration (FDA), Medicare and the United States Health Care Financing Administration (HCFA) AND which are not investigative or experimental and meet the following criteria:

1. Medically necessary and appropriate;
2. Not considered experimental surgery.

Transplants are covered subject to the following limitations:

1. Expenses incurred for organ procurement from a non-living donor cannot exceed $10,000 per transplant.

COVERED MEDICAL EXPENSES (cont.)

2. Expenses incurred for organ procurement from a living donor cannot exceed $25,000 per donor's lifetime;
3. Expenses incurred for transportation, lodging and meals combined cannot exceed $200 per day and $10,000 per transplant. This is limited to one (1) adult to accompany the patient or two (2) adults if the covered recipient/donor is a minor;
4. Benefits available for transplant procedures are subject to a lifetime maximum of $1,000,000.

   When the recipient is a covered person, the Plan will pay for organ donor charges up to the maximums stated above provided the organ donor does not have coverage elsewhere that will pay for the charges. Charges incurred for the organ donor (if any) will apply towards the organ recipient's lifetime maximum payable under this Plan; however, if the donor is also covered under this Plan, any donor charges will apply towards the donor's lifetime maximum payable under this Plan. Donor charges will not be considered an eligible expense under this Plan if the recipient is not a person covered under this Plan.

Charges incurred for Growth Hormones when determined to be medically necessary.

Chiropractic services rendered by a Doctor of Chiropractic will only be covered for the detection and correction by manual or mechanical means, including x-rays incidental thereto, the structural imbalance, distortion or partial dislocation in the human body for the removal of nerve interference as the result of, or related to, distortion, misalignment or partial dislocation.

Charges incurred for acupuncture only if performed by a Medical Doctor as an alternative form of medically necessary anesthesia.

Speech Therapy by a Certified Speech Therapist to restore speech loss or correct an impairment due to a congenital defect or an injury or sickness.

Services for treatment of mental or nervous disorders subject to the limitations stated in the Schedule of Benefits. Charges incurred for alcoholism and drug abuse by a state-approved and licensed institution that is engaged in treating alcoholism or drug abuse subject to the limitations stated in the Schedule of Benefits.

Home Health Care charges as defined herein.

Pre-admission testing as stated within seven (7) days prior to a hospital admission.

Second surgical opinions (and third surgical opinions if necessary) as stated herein.

COVERED MEDICAL EXPENSES (cont.)

Christian Science Services. Benefits are payable under the Plan for: (a) Expenses incurred for present treatment for healing purposes provided by a Christian Science practitioner. At the time such treatment is made, the practitioner must be accredited by the Mother Church, the First Church of Christ, Scientist, in Boston, Massachusetts. Such charges are subject to the same terms and conditions as if they had been made by a physician; (b) Expenses incurred for private nursing care provided by a Christian Science nurse. At the time such care is rendered, the nurse must be accredited by the Mother Church, the First Church of Christ, Scientist in Boston, Massachusetts. Such charges are subject to the same terms and conditions as if they had been made by a registered Graduate Nurse; (c) Expenses incurred for room and board while confined for healing purposes in a Christian Science Sanatorium. The Sanatorium must be (1) currently maintained by the Mother Church, The First Church of Christ, Scientist, In Boston Massachusetts; or (2) accredited by the Committee on Christian Science Nursing Homes of the Mother Church. Such charges are subject to the same terms and conditions as if the charges had been incurred in a Hospital.

Breast reconstruction in connection with mastectomy is covered (subject to all Plan provisions) as follows:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce symmetrical appearance; and
3. Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedema; in a manner determined in consultation with the attending physician and the patient.

Coverage following a mastectomy for a length of time determined by the attending physician to be medically necessary and in accordance with the protocols and guidelines based on sound scientific evidence and upon availability of a post-discharge physician office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.

An annual cervical smear or pap smear test for covered females, and an annual digital rectal examination and a prostate-specific antigen test, for covered males upon the recommendation of a physician licensed to practice medicine in all its branches for:

- Asymptomatic men age 50 and over
- African-American men age 40 and over; and
- Men age 40 and over with a family history of prostate cancer.

Coverage for colorectal cancer screening with sigmoidoscopy or fecal occult blood testing once every three (3) years for persons who are at least 50 years old.

Coverage for colorectal cancer screening for persons classified as high risk for colorectal cancer because the person or first-degree family member of the person has a history of colorectal cancer. This coverage applies to person who has attained at least 30 years of age.

COVERED MEDICAL EXPENSES (cont.)

Outpatient self-management training and education, equipment, and supplies for treatment of type 1 diabetes, type 2 diabetes and gestational diabetes mellitus.

1. Coverage for diabetes self-management training, including medical nutrition education may be limited to the following:
   - Up to three (3) medically necessary visits to a health care professional upon initial diagnosis of diabetes by the patient's physician.
   - Up to two (2) medically necessary visits to a health care professional upon determination by a patient's physician that a significant change in the patient's symptoms or medical condition has occurred.

   Payment by the Plan for the coverage required for diabetes self-management training is only required to be made for services provided. No coverage is required for additional visits beyond those specified above.

2. Medically necessary supplies when prescribed by physician for:
   - Blood glucose monitors
   - Blood glucose monitors for the legally blind
   - Cartridges for the legally blind
   - Lancets and lancing devices

3. Medically necessary pharmaceuticals and supplies when prescribed by a physician for:
   - Insulin
   - Syringes and needles
   - Test strips for glucose monitors
   - FDA approved oral agents used to control blood sugar, and
   - Glucagon emergency kits.

4. Regular foot care exams by a physician.

Birth control pills are covered through the Retail Drug Plan. Effective October 1, 2003, all other means of prescribed birth control prevention, including but not limited to injections and Norplant implants, will be payable under the Major Medical Plan.

MATERNITY/NEWBORN COVERAGE

MATERNITY COVERAGE: Benefits for maternity services are considered the same as an illness for:

1. An employee
2. An employee's spouse
3. A COBRA participant - only if that participant was an employee or spouse of an employee prior to becoming a COBRA participant.

Dependent children (as defined) are not eligible for maternity coverage.

Group Health Plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

NEWBORN COVERAGE: Expenses incurred for hospital, surgical and medical services for a newborn child during hospital confinement immediately following birth, are covered on the same basis as for an illness. Newborns are covered from birth for any services required and services due to illness or accident subject to the Eligibility and Effective Date provisions stated herein.

DENTAL BENEFITS

DEDUCTIBLE: The deductible as stated in the Schedule of Benefits applies per calendar year to each covered person.

FAMILY DEDUCTIBLE: The family deductible as stated in the Schedule of Benefits applies per calendar year to each covered family.

DEDUCTIBLE CARRYOVER: Any amount applied toward the deductible by charges incurred on or after October 1st, will go toward the satisfaction of the next calendar year deductible.

CALENDAR YEAR MAXIMUM: The calendar year maximum benefit per covered person is stated in the Schedule of Benefits for Class I, II, and III combined. The calendar year maximum benefit per covered family is stated in the Schedule of Benefits for Class I, II, and III combined.

COVERED CHARGES:

Covered dental expenses include reasonable and customary expenses prescribed by a dentist incurred for the services and supplies listed in this section provided for or in connection with medically necessary dental treatment. Some exclusions may apply to these covered dental expenses. Please also read the Exclusions and Limitations provision of this section.

Reasonable and customary expenses are the usual charge made for dental care, services or supplies not exceeding the general level of charges made for similar services, medicines or supplies, within the geographical area in which the services are rendered. The term "Area" as it would apply to any particular service, medicine or supply, means a county or such greater area necessary to obtain a representative cross-section of level of charges.

Charges incurred by a covered person are only covered while his coverage is in effect. Charges will be considered for the following:

1. A crown, bridge or cast restoration. Such services are considered incurred on the date the tooth is prepared;
2. Prosthetic devices. Such services are considered incurred on the date the master impression is made, and
3. Root canal treatment. Such services are considered incurred on the date the pulp chamber is opened.
4. All other covered charges will be considered incurred on the date such services are furnished.

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

PRE-TREATMENT REVIEW

When the expected cost of a proposed course of treatment is $125 or more, the covered person's dentist should send a treatment plan before dental treatment starts. The treatment plan should include:

1. A list of services to be performed, using the American Dental Association Nomenclature and codes;
2. The itemized cost of each service; and
3. The estimated length of treatment. Dental x-rays, study models and other items necessary to evaluate the treatment plan should also be sent.

The treatment plan will be reviewed and an estimate will be sent to the covered person's dentist. If there is a disagreement with a treatment plan, or if a treatment plan is not sent in, the payments will be based on treatment suited to the covered person's condition by accepted standards of dental practice.

The pre-treatment review is not a guarantee of payment; it does, however, tell the covered person and his dentist in advance what charges are covered subject to Plan provisions. Payment is conditioned on the following:

1. The work being performed as proposed while the covered person is covered, and
2. The deductible and payment limit provisions.

LIST OF COVERED DENTAL SERVICES

The services covered by this Plan are stated below. Each service on this list has been categorized by Class. Deductibles and payment rates are as shown in the Schedule of Benefits.

All covered dental services must be furnished by, or under the direct supervision of, a dentist, and they must be usual and necessary treatment for a dental condition.

CLASS I PROCEDURES - PREVENTIVE

Preventative Dental Services

(A) Routine oral examinations, including diagnosis and x-rays, up to a maximum of two (2) examinations per calendar year,

(B) Prophylaxis (cleaning, scaling and polishing), up to a maximum of two (2) treatments per calendar year,

(C) Topical fluoride application.

(D) Sealants, for covered dependents under age 16.

CLASS II – PRIMARY DENTAL SERVICES

Primary Dental Services

(A) Fillings,
(B) Extractions,
(C) Oral surgery. Oral surgery means: (1) Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth; (2) Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth, provided that the injury occurred on or after the covered person's or covered dependent's eligibility date under the Plan; (3) 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 of ducts; reduction of dislocation, or excision of, the temporomandibular joints; (4) Surgical extraction of impacted wisdom teeth,
(D) Endodontics,
(E) Periodontics, including gingivectomy and gingivoplasty, gingival curettage, osseous surgery, surgical periodontic examination, mucogingivoplastic surgery and management of acute periodontal infection and oral lesions,
(F) Anesthesia, if administered in conjunction with performance of another covered dental procedure,
(G) Emergency treatment for relief of pain.

CLASS III – MAJOR DENTAL SERVICES

Major Dental Services

(A) Inlays, onlays and crowns,
(B) Charges for installing for the first time, or for adding to, a denture or fixed bridge if:
 (1) The work is needed due to extraction of injured or diseased natural teeth and is finished within 12 months of the date the tooth was extracted; and
 (2) The tooth is extracted while the patient is covered for these benefits; and
 (3) The work includes replacing the extracted tooth.

 A denture or bridge is considered to be installed for the first time if it does not replace any existing denture or bridge.
(C) Charges for replacing or altering a denture or fixed bridge if:
 (1) The change is needed due to one of these events:
  (a) An accidental injury requiring oral surgery; or
  (b) Oral surgery which involves changing the position of muscle attachments, or removing a tumor, cyst, torus or excess tissue; and
 (2) The event occurs while the patient is covered for these benefits; and
 (3) The work is finished within 12 months after the event.

(D) Charges for replacing a dull denture if needed due to a change in the structure of the mouth or due to wear and tear of the denture, if replaced after the later of:
   (1) Five (5) years after the date the denture is installed; or
   (2) Two (2) years after the date the patient became covered for these benefits.
(E) Charges for repairing a denture or bridge.

DENTAL EXCLUSIONS – the following limitations apply to benefits provided pursuant to the Dental Benefits section in addition to those limitations in the Health Plan Exclusions and Limitations section herein which are applicable to all benefits provided under the Plan.

Dental services not ordered by a physician.

Dental services which do not meet the standards set by the American Dental Association.

Dental services incurred due to loss or theft of dentures or bridges.

Dental services obtained from a health department maintained by the Employer, a union, a trustee or a similar type of entity.

Dental services obtained for cosmetic reasons, including altering or extracting and replacing sound teeth to change appearance.

The following items:

(a) myofunctional therapy
(b) orthodontic treatment
(c) athletic mouthgaurds
(d) implants
(e) oral hygiene, dietary, plaque control and other educational programs
(f) duplicate prosthetic appliances
(g) 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
(h) gold inlays or onlays

Dental services for an injury or sickness due to employment with an employer or self-employment where worker's compensation benefits are available.

Services and supplies not specifically mentioned in the Plan.

HEALTH PLAN EXCLUSIONS AND LIMITATIONS

The following charges are not covered under this Plan:

Pre-Existing Conditions as defined by the Plan.

Charges incurred for routine health examinations, vaccinations, inoculations, multiphasic screening tests and physician check-ups not associated with any sickness, injury or condition requiring professional service or treatment, except as defined herein. This is also to include pre-marital and pre-employment examinations.

Charges incurred for services or supplies which constitute personal comfort or beautification items. This is to include (but not be limited to) television, telephones and wigs.

Charges for custodial care that does not serve to cure the person of any sickness or injury, except for charges related to Hospice Care or Home Health Care, as defined herein.

Any treatment or service resulting from sickness or injury which is covered by a Workers' Compensation Act or other similar legislation.

Charges incurred for glasses or eye examinations for the correction of vision or fitting of glasses or contact lenses. Charges incurred for any treatment for myopia (nearsightedness), hyperopia (farsightedness), astigmatism, radial keratotomy, keratoplasty or any other surgeries on the eye to correct vision.

Charges incurred for treatment of weak, strained or flat feet, or instability or imbalance of the feet are not covered. This includes orthopedic shoes and other supporting devices. Also, charges for removal or treatment of corns, calluses, bunions or toenails (unless at least part of the nail root is removed) unless surgical removal through an open cutting operation is performed, or treatment is needed due to disease or injury.

Charges incurred for instruction or activities for weight reduction, weight control or physical fitness, even if the services are performed or prescribed by a physician, except as stated herein.

Travel, whether or not recommended by a physician, except as stated herein.

Charges incurred for well child care after the child is discharged from hospital immediately following birth, except as specifically stated herein. Should a child require care other than routine care, the charges incurred will be considered as any other covered expense.

Services for Temporomandibular Joint Syndrome.

Replacement of cataract lenses when a prescription change is required or the prescribing and fitting of an artificial eye.

HEALTH PLAN EXCLUSIONS AND LIMITATIONS (cont.)

Charges incurred for treatment on or to the teeth, oral surgery, the nerves or roots of the teeth, gingival tissue or alveolar processes, except as stated herein. Please refer to the Dental Benefits section for oral surgery benefits.

Hospitalization, services or supplies that are not medically necessary and reasonable for treatment of the injury or illness.

Charges incurred in connection with cosmetic surgery, except to correct a condition resulting from accidental bodily injury sustained while the individual was covered under the Plan or to correct a congenital anomaly in an eligible dependent, except as stated herein with regard to breast reconstruction in connection with mastectomy.

Charges incurred for hearing aids, batteries or repairs.

The 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.

Charges for treatments or procedures that are investigative or experimental for the patient's diagnosed sickness or injury. A drug, device, medical treatment or procedure is considered to be investigative or experimental if the drug, device, medical treatment or procedure cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug, device, medical treatment or procedure is furnished. This Plan will consider reliable medical evidence when making benefit determination. Reliable medical evidence shall include documented and peer-reviewed literature or reports and guidelines published by nationally recognized health care organizations, and the written protocol or protocols used by the treating facility or another facility studying substantially the same drug, device, medical treatment or procedure. Charges will not be payable if there is insignificant outcome data available from controlled clinical trials or from medical literature to show the treatment or care is safe and effective.

Charges incurred for the replacement of a prosthesis, except when required by the covered person's growth to maturity, necessary change in prescription, (only if pre-approved by the Plan Sponsor), or accidental bodily injury.

Charges incurred for the purchase or rental of physical fitness equipment, humidifiers, corrective shoes, air purifiers, air-conditioners, water purifiers, hypoallergenic pillows, mattress or waterbed, motorized transportation equipment (motorized transportation equipment will be covered if a covered person is not physically capable of operating non-motorized equipment), escalators, elevators, saunas, steamrooms, swimming pools and other such items that may be excluded by the Plan Sponsor on a uniform non-discriminatory basis.

HEALTH PLAN EXCLUSIONS AND LIMITATIONS (cont.)

Charges incurred for preparing medical reports, itemized bills, mailing expenses, failure to keep a scheduled visit, completion of a claim form, sales tax or finance charges.

Charges incurred for vitamins (other than prenatal), nutritional supplements, contraceptives (unless medically necessary or for birth control pills), and treatment of a nicotine habit except as stated herein. **Birth control pills are covered through the Retail Drug Plan. Effective October 1, 2003, all other means of prescribed birth control prevention, including but not limited to injections and Norplant implants, will be payable under the Major Medical Plan.**

The Plan will not reimburse drugs purchased without use of the Prescription Drug Card or through the Mail-Away Program. This does not apply to diabetic supplies, blood glucose meters or insulin.

Any treatment or service rendered by a member of the immediate family (spouse, child, brother, sister or parent of the covered person).

Services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustees or similar person or group.

Services or supplies for sexual reassignment (inter-sex surgery, gender dysphoria surgery) or for the complications thereof.

Facility charges made during periods when the covered person is temporarily absent from the medical facility.

Maternity services in relation to a surrogate mother.

Charges incurred for chelation therapy.

Biomicroscopy, field charting or aniseikonia investigation.

Orthopic or visual training.

Professional nursing services if rendered by other than a Registered Graduate Nurse or LPN, unless such care was vital as a safeguard of the covered person's life and unless such care is specifically listed as a benefit elsewhere in this Plan.

Charges incurred in connection with the care or treatment of any sickness contracted or injury sustained which results from war, declared or undeclared, or any act of war. Accidental bodily injury or sickness contracted while on duty with any military, naval or air force of any country or international organization.

HEALTH PLAN EXCLUSIONS AND LIMITATIONS (cont.)

Charges incurred for services or supplies that are furnished, paid for, or otherwise provided by a government, other than the U. S. Government. Any treatment or service that is compensated for or furnished by the local, state or federal governments, where not prohibited by law.

Charges that would not have been made if no coverage existed or charges that neither a primary covered person or any of his dependents is under legal obligation to pay.

Charges incurred for non-medical expenses such as training, IQ testing, educational instructions or educational materials, even if they are performed or prescribed by a physician, except as stated herein.

Charges for services and supplies that are not necessary for treatment of the injury or illness, or are not recommended and approved by the attending physician, or charges to the extent that they are unreasonable.

Charges incurred outside the United States if the covered person traveled to such a location for the sole purpose of obtaining services, supplies or treatments.

Claims not submitted within the Plan's filing limit deadlines as specified in the General Provisions section herein.

Charges incurred for treatment of sickness or injuries sustained (a) while operating a motor vehicle or motor boat under the influence of alcohol or other drug or controlled substance that is not prescribed by a physician, or (b) during the commission of a felony, will not be considered an eligible expense under the Plan. However, charges will be considered under the Plan if any of these events occurred as a result of a medical condition of the covered person. For the purposes of this section, a person shall be presumed to be under the influence of alcohol if such person's blood alcohol level equals or exceeds the limit for driving under the influence of alcohol as determined by the law of the state in which the injury occurred. A person shall be considered to be under the influence of alcohol or controlled substance, that is not prescribed by a physician, if objective evidence suggests such condition. "Objective evidence" for this purpose shall mean a blood test, lab test, or breathalyzer test. The limitations of this section shall not apply unless there is a direct casual relationship between the activity described in (a) or (b) above and the sickness or injury sustained.

Services and supplies not specifically mentioned in the Plan.

PRE-EXISTING CONDITION LIMITATION

PRE-EXISTING LIMITATION

The Pre-Existing Condition Limitation does not apply to new hires (and their eligible dependents, if any) that enroll within 30 days of the Enrollment Date. If an employee (and his eligible dependents, if any) does not apply within 30 days of the Enrollment Date, the Pre-Existing Condition Limitation applies as follows:

For the purposes of this Plan, a pre-existing condition means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment (this includes taking prescribed drugs) was recommended or received within the six (6) month period ending on the enrollment date, as defined herein. Medical advice, diagnosis, care or treatment is considered only if it is recommended by, or received from a licensed individual operating within the scope of the individual's license, if licensing is required, or if not required, within the scope of the individual's practice.

Pre-existing conditions may not apply to newborns, adopted children or children placed for adoption before age 18, enrolled in this Plan within 31 days of birth, adoption, or placement for adoption. Pregnancy may not be considered a pre-existing condition.

Further, the pre-existing limitation or exclusion will extend for a period of 12 months (18 months in the case of a late entrant) after an individual's enrollment date.

This Plan will credit periods of previous coverage toward a pre-existing condition period by accepting certificates of coverage showing prior creditable coverage. (Covered persons have the right to request certificates of coverage from a prior plan or issuer showing prior creditable coverage, if any.) In addition to the above, to avoid a pre-existing limitation or exclusion, a covered person must not experience a significant break in coverage for 63 days or more (waiting periods are not considered a break in coverage nor are they considered as creditable coverage). If a significant break in coverage of 63 days or more occurs, portability of health coverage is lost.

An employee will be given credit for time in active service with the employer while covered under such immediately prior health plan offered by the employer (and an eligible dependent will be given credit for time while covered under such immediately prior plan) toward satisfaction of time requirements imposed under this provision.

DEFINITIONS

The terms below, whenever used in this Document are defined as follows:

ACTIVE EMPLOYEE: An active employee is an employee who performs all of the duties of his job with the employer on a permanent full-time basis and who has begun work for the employer. To be full-time, an active employee must be scheduled to work for the employer at least 30 hours (or more) per week and on the regular payroll of the employer.

ADVERSE BENEFIT DETERMINATION: A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a covered person's eligibility to participate in a plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

AGENT FOR SERVICE OF PROCESS: Process may be served on the employer (Plan Sponsor) or the Plan Trustee (if any) at the address indicated in the Benefit Plan Summary Description provision.

ALTERNATE RECIPIENT: An Alternate Recipient is any child of a participant who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under a Group Health Plan with respect to such participant.

AMBULATORY SURGICAL CENTER: A private or public establishment with an organized medical staff of physicians with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures with continuous physician services and registered professional nursing services. Such services must be provided whenever a patient is in the facility and such facility must not provide services or other accommodations for patients to stay overnight.

APPROVED LEAVE OF ABSENCE: A leave of absence authorized by the employee's employer, including an absence from the employer due to a suspension whether such suspension is paid or unpaid.

CALENDAR YEAR: A period of time commencing at 12:01 a.m. on January 1st, and ending at 12:01 a.m. on the next succeeding January 1st. Each succeeding like period will be considered a new calendar year.

CLAIM: For the purposes of this Plan, a claim for benefits is a request for a Plan benefit or benefits made by a claimant in accordance with the Plan's reasonable procedure for filing benefit claims.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985.

DEFINITIONS (cont.)

COSMETIC SURGERY: Surgery that is intended to:

1. Improve the appearance of a patient, or
2. Preserve or restore a pleasing appearance. It does not mean surgery that is intended to correct normal functions of the body.

COVERED PERSON: A person eligible under this Plan, as defined in the Eligibility provision. A covered person refers to all persons covered under this Plan, unless the person is further defined as a primary covered person, employee, dependent, COBRA participant or alternate recipient.

CUSTODIAL CARE: Care consisting of services and supplies provided to a covered person, in or out of an institution, primarily to assist him in daily living activities, whether he is or is not disabled.

DEPENDENT: An employee's spouse (unless legally separated), of the opposite sex, who is a resident of the same country in which the employee resides.

An employee's child who meets all the following conditions:

1. Is a legal resident of the same country in which the employee resides;
2. Is unmarried;
3. Is a natural child, legally adopted child, foster child, or child that has been placed for adoption (such covered person must have assumed legal obligation for total or partial support of such child in anticipation of adoption) in the household of such covered person who is chiefly dependent upon the employee for support and maintenance. The child's placement for adoption with such covered person terminates upon the termination of such legal obligation. After such legal adoption, the child is considered to be an adopted child. A child is also a covered person's stepchild residing in the primary covered person's household and who is dependent upon the primary covered person for support and maintenance, or is a child that the covered person is required by a Qualified Medical Child Support Order to cover under his Group Health Plan, or a child for which the covered person has been granted legal custody or guardianship, and where required by applicable state law, any child of an unmarried minor female dependent of the employee. Notwithstanding any provision herein to the contrary, grand children are not considered eligible dependents under this Plan.
4. Is less than 19 years old. However, a child who is less than 23 years and is primarily dependent upon the employee for support and is in regular full-time attendance, (as recognized by the institution), at an accredited institute of learning including intervening holidays or vacations between periods of full-time attendance, and including a period of up to 120 days following completion of a period of full-time attendance. If a student turns age 23 during this 120 day period, coverage will cease on the day the dependent attains age 23.

Children who are incapable of self-sustaining employment by reason of mental retardation or physical handicap will be eligible for coverage under the Plan provided such incapable child became incapable prior to attainment of the termination age stated herein. An incapacitated child must be primarily financially dependent upon the Primary covered person for support and maintenance. Such child may continue coverage past the terminating age stated above, provided the employee's coverage remains effective.

ELECTIVE SURGICAL PROCEDURE: Any non-emergency surgical procedure which may be scheduled at a patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

ELIGIBILITY DATE: An employee is eligible to enroll for coverage on the first day of active work with the Employer. For the purposes of this Plan, eligibility date is the first day of active work with the Employer.

ELIGIBLE PARTICIPANT: Eligible Participant is a covered person of this Plan for which a court of competent jurisdiction has issued a Qualified Medical Child Support Order (QMCSO) to an alternate recipient stating that such eligible participant is required to provide coverage to such alternate recipient under a Group Health Plan.

ENROLLMENT DATE: The enrollment date is the first day of coverage under a Plan.

EXPENSES INCURRED: The charge for a service or supply which is considered to be incurred on the date it is furnished.

EXTENDED CARE/SKILLED NURSING FACILITY: An institution that is licensed as an extended care or skilled nursing or long-term care facility. Such facility must be qualified to participate and eligible to receive payments under, and in accordance with, the provisions of the Medicare Program or a licensed agency established and operated under all applicable law. Such facility must not be, other than incidentally, a home for the aged or domiciliary care home, and must meet all of the following requirements:

1. Maintains permanent and full-time facilities for bed care of 10 or more resident patients. If such facility is part of a hospital, it must maintain permanent and full-time facilities for bed care of five (5) or more resident patients;
2. Has available, at all times, the services of a physician;
3. Has a Registered Professional Nurse (R.N.) on full-time duty in charge of patient care and one (1) or more Licensed Practical Nurses (L.P.N.) on duty at all times;
4. Maintains a daily medical record for each patient;
5. Is primarily engaged in providing continuous nursing care for sick or injured persons during the convalescent stage of their illnesses or injuries and is not, other than incidentally, a rest home or a home for custodial care for the aged; and
6. IS NOT an institution primarily engaged in the care and treatment of drug addicts or alcoholics.

DEFINITIONS (cont.)

FAMILY MEMBER: A primary covered person or his dependent(s).

FULL TIME EMPLOYEE: A person who is scheduled to work at least 30 hours per week (or less if absent from work due to sickness, injury or approved leave of absence), excluding vacations and holidays, and who is on the permanent payroll of the employer and specifically excludes a seasonal or part-time employee.

FUNDING: Funding for payment of health benefits are paid into an Employee Welfare Benefit Trust from which claims are paid.

All funds received by the Trust shall be applied towards payment of benefits and reasonable expenses of administration of the Plan.

HEALTH CARE PROFESSIONAL: A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

HIPAA: The Health Insurance Portability and Accountability Act of 1996.

HOME HEALTH CARE AGENCY: An agency which is primarily engaged in furnishing home nursing care and other therapeutic services for persons recovering from a sickness or injury and which is:

1. Qualified for payment under the Federal Medicare program; or
2. A licensed agency established and operated under all applicable law.

The term "Home Health Care" shall consist of:

1. Part-time nursing care rendered in the person's home by a Registered Professional Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), a Licensed Public Health Nurse. A Licensed Vocational Nurse or Home Health Aide under the supervision of a Registered Professional Nurse. One (1) visit of home health care is considered to be care received in one (1) calendar day not to exceed four (4) during any 24 hour period.
2. Physical, occupational, or speech therapy, provided in the person's home.
3. Physical, occupational, or speech therapy, or the use of medical appliances or equipment provided on an outpatient basis by a home health agency, or by a hospital or other facility under an arrangement with a home health agency.

DEFINITIONS (cont.)

HOSPICE CARE AGENCY: An institution or agency, licensed as a Hospice and certified to receive payment under the Medicare program, which provides palliative care and management of a covered person whose life expectancy is six (6) months or less. Hospice care may be provided through either:

1. A centrally administered, medically directed and nurse-coordinated program which provides a coherent system primarily of home care, uses a Hospice Team and is available 24 hours a day, seven (7) days a week; or
2. Confinement in a Hospice.

The Hospice program must meet standards set by the National Hospice Organization and be recognized as a Hospice Care Program by the Plan Sponsor. If such a program is required by law to be licensed, certified, or registered, it must also meet that requirement to be considered a Hospice Care Program.

HOSPICE TEAM: A team of professionals and volunteer workers who provide care to reduce or abate pain or other symptoms of mental or physical distress. Such team should serve the special needs arising out of the stress of the terminal illness, dying and bereavement. The team may include a physician, registered social worker, clergyman/counselor, volunteers, clinical psychologist, physiotherapist and/or occupational therapist.

HOSPITAL: An institution which is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patient's expense and which fully meets all the requirements set forth in 1. and, 2. or, 3. below:

1. It is an institution which is operating in accordance with the laws of the jurisdiction in which it is located pertaining to institutions identified as hospitals; is primarily engaged in providing for compensation from its patients and on an inpatient basis, diagnosis, treatment and care of injured or sick persons by or under the supervision of a staff physician or surgeon; continuously provides 24 hour nursing services by Registered Professional Nurses, maintains facilities on the premises for major operative surgery, and is not, other than incidentally, a place for rest, a place for the aged, a place for the treatment of drug addiction, alcoholism, or a place for the mentally ill or the emotionally disturbed (unless such institution meets the criteria of paragraph 3. below), or a nursing home; Such institution must be accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);
2. It is a psychiatric hospital as defined by Medicare, which is qualified to participate in, and is eligible to receive payments under and in accordance with, the provisions of Medicare;
3. Notwithstanding paragraph 1., the term "hospital" also means an institution primarily engaged in the treatment of drug addiction, alcoholism or a place for the mentally ill or the emotionally disturbed if such institution meets all of the following requirements:
   (a) Appropriately licensed and legally operating in the jurisdiction in which is located;
   (b) Maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients;
   (c) Has a physician in regular attendance;

(d) Continuously provides 24 hour a day nursing service by Registered Professional Nurses;
(e) Has a full-time psychiatrist or psychologist on the staff; and
(f) Is primarily engaged in providing diagnostic and therapeutic services and facilities for the treatment of alcoholism, drug dependence, or mental illness.

INJURY: A bodily injury, resulting from a sudden external violent cause.

LARGE CASE MANAGEMENT: Case Management for the purposes of this Plan, means a program managed by an authorized representative of the Plan Sponsor with the goal of assessing the medical necessity and appropriateness of care and treatment provided to a person covered under this Plan. Other goals include opening the lines of communication among providers of care (or services), patients and employers (Plan Sponsor), and identifying and utilizing the most cost-effective medical care providers and services while maintaining professional standards of care. This may also include the recommendation and arrangement for alternative services not otherwise covered under the Benefit Plan.

Such a program may include, but will not be limited to the following:

1. Pre-certification of hospital admissions
2. Concurrent and retrospective review of hospital admissions
3. Second and or third surgical opinion reviews
4. Other alternative forms of managed care which are medically appropriate to the symptoms and diagnoses of the patient and rendered according to general accepted medical practice and professional standards of care.

It is not the intent of the Plan Sponsor to expand the coverage offered under the terms of the Plan unless specifically agreed upon and approved by the Plan Sponsor.

LATE ENROLLEE: A late enrollee (or late entrant) is an individual whose enrollment in a plan is due to late enrollment. A late enrollment means enrollment in a group health plan other than on:

1. The earliest date on which coverage can become effective under the plan; or
2. A special enrollment period (as stated in the Eligibility section).

A late enrollee (or late entrant) no longer has to provide evidence of good health, however, the Plan can apply a pre-existing condition limitation on any pre-existing conditions up to a maximum of 18 months, reduced by any prior creditable coverage, for such late enrollee.

If an individual ceases to be eligible under a plan by terminating employment and then becomes eligible for coverage again by returning to employment, only the most recent period of employment is considered.

That is, the fact that the individual was a late enrollee the first time the individual was hired will not cause the person to be a late enrollee if the person terminates and is rehired in the future. The person's future status will depend on whether enrollment was timely at the later re-enrollment.

LICENSED PRACTICAL NURSE: A professional person who has had one (1) or more years of specialized training beyond high school in a state-approved school of nursing, and who has passed a written examination administered by the state authority. Such Licensed Practical Nurse must be licensed to perform nursing services by the state in which the person performs the service.

LIFETIME MAXIMUM(S): Any reference in this Plan to lifetime maximum(s) refer only to the period of time the covered person is covered for benefits under the Plan Sponsor's Benefit Plan.

MEDICAL NECESSITY: Medically necessary hospitalizations, services or supplies which are required for treatment of the sickness or injury for which they are performed. Such services must be based on documented and peer-reviewed literature or contained in reports and guidelines published by nationally recognized health care organizations, approved by specialists in the relevant field, appropriate for the covered person's health status and likely to produce a significant positive outcome, and must be provided in the most cost-efficient manner. The fact that a physician may prescribe, order, recommend or approve a hospitalization service or supply, does not of itself, make it medically necessary or make the charge eligible for payment even though it is not specifically listed as an exclusion. The Plan Sponsor reserves the right to determine the medical necessity for a hospitalization, service or supply based upon an established, uniform, non-discriminatory policy of professional medical review for any such service.

NAMED FIDUCIARY: The person who has the authority to control and manage the operation and administration of the Plan. The Named Fiduciary for the Plan is the employer (Plan Sponsor).

NECESSARY SERVICE OR SUPPLY: A service or supply is considered necessary only if it is broadly accepted professionally as essential to the treatment of the disease or injury.

NON-OCCUPATIONAL: A disease or injury which does not arise from, and which is not caused by, contributed by or as a consequence of, any disease or injury which arises out of, or in the course of, any employment or occupation for compensation or profit that is compensable through Workers' Compensation Act or like program.

NOTICE OR NOTIFICATION: The delivery or furnishing of information to an individual in a manner that satisfies standards appropriate with respect to material required to be furnished or made available to an individual.

OUTPATIENT: Treatment at a hospital, clinic, physician's office, or ambulatory surgical center where the patient is not hospitalized as a bed patient. If such patient is not discharged, but is hospitalized as an inpatient immediately following such outpatient treatment, benefits will be payable on an inpatient basis.

PHYSICAL HANDICAP: A physical or mental defect or characteristic, congenital or acquired, preventing or restricting a person from participating in normal life or limiting his capacity to work.

DEFINITIONS (cont.)

PHYSICIAN: A licensed doctor of medicine (M.D.); doctor of osteopathy (D.O.); optometrist; dentist; podiatrist; chiropractor; midwife; a clinical or child psychologist, holding a doctor of philosophy degree (Ph.D.); a clinical or child psychologist holding a master's degree (M.A. or M.S.); or a masters in social work (M.S.W.) or licensed professional counselor (when licensing is required by the state in which the counselor resides), and whose work is supervised directly by either a psychiatrist (M.D.) or a clinical psychologist (Ph.D.). Physician may also include other licensed practitioners operating within the legal scope of the licensure as specifically recognized under this Plan.

PHYSICIAN SERVICES VISIT: A personal interview between the patient and a physician. This does not include telephone calls or interviews in which the physician does not see the patient for treatment.

PLACEMENT FOR ADOPTION: The term "placement," or being "placed," for adoption in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such covered person terminates upon the termination of such legal obligation. After such legal adoption, the child is considered to be an adopted child.

PLAN SPONSOR: The Company and any affiliated company which has adopted this Plan. Plan Sponsor may also be referred to as Plan Administrator, Administrator, or Employer.

POST-SERVICE CLAIM: Any claim for benefit under a group health plan that is not a Pre-Service claim. Post-service claims will never constitute claims for urgent care. Post-service benefit determinations must be made within 30 days from the date the claim is filed. This period may be extended one time by the Plan, for up to 15 days, provided the Third Party Administrator (TPA) 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 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

PRACTITIONER: A Christian Science Practitioner accredited by the Department of Care of the First Church of Christ Scientist, Boston, Massachusetts.

DEFINITIONS (cont.)

PRE-EXISTING CONDITION: For the purposes of this Plan, a pre-existing condition means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment (this includes taking prescribed drugs) was recommended or received within the six (6) month period ending on the enrollment date. Medical advice, diagnosis, care or treatment is considered only if it is recommended by, or received from a licensed physician operating within the scope of the individual's practice. Please refer to the Pre-Existing Condition Limitation section for further Pre-Existing condition information.

PRE-SERVICE CLAIM: A claim for benefit under a group health 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 obtaining medical care. Pre-service benefit determinations must be made within 15 days from the date the claim is filed. This period may be extended one time by the Plan, for up to 15 days, provided the Third Party Administrator (TPA) 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 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

PREFERRED PROVIDERS: Hospitals that have been carefully screened and reviewed for certification of medical education, medical licensure, malpractice history and level of patient care and commitment to cost containment.

PRIMARY COVERED PERSON: An eligible employee, eligible retired employee (if retiree coverage is available), an eligible surviving spouse (if surviving spouse coverage is applicable), or an eligible COBRA participant, other than eligible COBRA dependents participating as dependents under a COBRA participant's coverage.

PRIOR CREDITABLE COVERAGE (or CREDITABLE COVERAGE): Prior creditable coverage is coverage under almost any type of medical plan (as stipulated in HIPAA), including group health plans, individual insurance, Medicare, Medicaid, CHAMPUS, Indian Health Service medical care or care through a tribal organization, state health benefits risk pools, the Federal Employees Health Benefits Program, a public health plan of a state, local or U.S. government or a political subdivision of a State (this also includes plans of a Foreign Government or a Foreign Country), a Peace Corps Plan, or a State Children’s Health Insurance Program (S-CHIP). Almost any medical plan coverage provided in this country, other than specifically excepted benefits (as stipulated under HIPAA or Regulations thereto) will count.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO): A Qualified Medical Child Support Order is any judgment, decree or order (including approval of a settlement agreement) issued by a court which requires an eligible participant to provide child support or health benefit coverage to a child under a Group Health Plan. For the purposes of OBRA 1993, "child" may also be referred to as an "alternate recipient". A Qualified Medical Child Support Order cannot require the Plan to provide any type or form of benefits not already provided by the Plan. See the Eligibility provision herein for qualifications of a Qualified Medical Child Support Order.

REASONABLE AND CUSTOMARY: The usual charge made for medical care, services or supplies not exceeding the general level of charges made for similar services, medicines or supplies, within the geographical area in which the services are rendered. The term "Area" as it would apply to any particular service, medicine or supply, means a county or such greater area necessary to obtain a representative cross-section of level of charges. Charges from a PPO provider/facility are allowed in accordance with the contract between the PPO and the provider/facility.

The determination of "Reasonable and Customary" charges shall be based upon Ingenix or equivalent.

REGISTERED PROFESSIONAL NURSE: A person who has had two (2) or more years of specialized training beyond high school in a state-approved school of nursing, has passed a written examination administered by the state authority and who is licensed to perform nursing services by the state in which the person performs such service.

RELEVANT DOCUMENT: A document, record, or other information shall be considered relevant to a claimant's claim if such document, record or other information (1) Was relied upon in making the benefit determination; (2) Was submitted, considered or generated in the course of making the benefit determination without regard to whether such document, record, or other information was relied upon in making the benefit determination; (3) Demonstrates compliance with the administrative processes and safeguards in making the benefit determination; or (4) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment opinion or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

SEMI-PRIVATE: The standard two-bed room accommodation for the prescribed level of care in the facility where services are rendered. In the event the hospital does not have semi-private rooms, the rate shall be deemed to be the room and board charges made by the hospital for the lowest priced private room accommodation.

SICKNESS: An illness or disease that results in loss covered by the Plan.

DEFINITIONS (cont.)

SIGNIFICANT BREAKS IN COVERAGE: A significant break in coverage refers to a break in coverage of 63 days or more. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if an individual has a break in coverage of at least 63 days, any creditable coverage before that break can be disregarded by a plan evaluating whether to impose a pre-existing condition limitation period. Waiting periods are not considered a break in coverage nor are they considered as creditable coverage.

SPEECH THERAPIST/SPEECH THERAPY AGENCY: An individual or institution (or part of an institution) which is licensed to provide speech therapy by the jurisdiction where the services are performed, if such licensing is required in such jurisdiction, or, in the absence of such licensing requirements, such therapist is certified, in the case of an individual, by the American Speech and Hearing Association, or, in the case of an institutional program, by the National Association of Speech and Hearing Agencies.

THIRD PARTY ADMINISTRATOR: The firm providing administrative services to the employer (Plan Sponsor) in connection with the operation of the Plan. The Third Party Administrator performs certain functions, at the direction of the Plan Sponsor, including enrollment applications, maintaining current Plan data, billing, processing and payment of covered benefits (from funds provided by the employer and employee, when required, for such purpose), and providing the employer with any other information deemed necessary by the Third Party Administrator.

TOTAL DISABILITY: A covered person who is completely unable, as a result of a non-occupational bodily injury or disease, to engage in any gainful occupation for which the covered person is reasonably fit by education, training or experience and is not performing work of any kind for wage or profit. A covered dependent will be considered totally disabled if, because of a non-occupational injury or disease, he is prevented from engaging in all the normal activities of a person of like age and sex who is in good health.

URGENT CARE CLAIM: Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (1) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (2) In the opinion of the physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Post-service claims will never constitute claims for urgent care. Benefit determination must be made within 72 hours from the date the claim is filed for urgent care claims.

WEEKEND ADMISSIONS: A hospital admission between Friday and Sunday. In the case of Sunday admission, weekend admission does not apply if the patient is scheduled for surgery on Monday a.m.

ELIGIBILITY

ELIGIBLE EMPLOYEE

An employee who is directly employed in the regular business of and compensated for services by the employer and regularly works full-time. An employee is considered to be working full-time if he works at least 30 hours per week (or less if absent from work due to sickness, injury or approved leave of absence), excluding vacations and holidays, and who is on the permanent payroll of the employer. When this Plan acquires new school districts that previously provided group health coverage to retirees of such plan, coverage for retirees currently covered under such plan at the time the school district was acquired by this Plan, will remain covered on the same basis as an active employee, or in the case of an IMRF employee, on the same basis as an IMRF employee. Otherwise, retiree coverage is not available under this Plan.

Part-time, temporary, seasonal, or substitute employees cannot be considered a covered person.

Each covered person who was covered under the Plan Sponsor's prior plan and who is active at work on the effective date of this Plan, becomes eligible for benefits on the effective date of this Plan. When this Plan acquires a new school district or other employer, each full-time employee of that entity effective as of the date of the acquisition, shall be deemed to be an active employee and active at work and eligible for benefits as of the date of the acquisition.

Any other employee hired on or after the effective date of this Plan becomes eligible for benefits on the date following attainment of status as a full-time employee and who has begun work with the Employer. However, if an employee is hired during summer months when school is not in session or other periods when school is not in session, coverage for such employee will not begin until the first day of work.

If an application is submitted within the 31 day period immediately following the individual's eligibility date, coverage will become effective on the employee's initial eligibility date.

ELIGIBLE COBRA PARTICIPANT

An eligible person electing continuation coverage under COBRA, as defined herein.

ELIGIBLE IMRF PARTICIPANT

A person eligible according to IMRF as defined in the IMRF section of this document.

ELIGIBLE DEPENDENT

An employee's spouse (unless legally separated), of the opposite sex, and an employee's dependent meeting the qualifications stated below:

In order for a child to be eligible for coverage under this Plan, such child must be one of the following:

1. A natural child of the employee;
2. A step-child of the employee;

ELIGIBLE DEPENDENT (cont.)

3. A child that the employee is required by law to be covered by the employee's medical care benefits;
4. A child who the employee has been granted legal custody or guardianship;
5. Where required by applicable state law, any child of an unmarried minor female dependent of the employee.

Provided a child is one as listed on the prior page, such child must meet all of the following conditions:

1. Unmarried and under age 19 or less than 23 if currently a full-time student in an accredited school;
2. Reside in the primary covered person's household (or a child that the covered person is required by law to cover under his Group Health Plan that does or does not reside with the primary covered person);
3. Be dependent on the primary covered person for support and maintenance.

Physically or mentally handicapped children, regardless of age, are covered upon presentation of proof of disability, if required, and as long as family coverage is maintained. No coverage will be provided to any child who is on active duty in the Armed Forces of any country.

Coverage for a live birth child to a covered employee or dependent spouse shall be effective from and after the moment of birth for covered medical expenses resulting from injury, sickness, premature birth of children under 5½ pounds, congenital conditions, and routine hospital, surgical and medical services provided the appropriate paperwork is filed with the Plan Sponsor within 31 days of birth. If other dependent coverage already exists on the day a newborn is born, coverage for such newborn child will become effective on the date of birth; however, no claims will be processed until the appropriate paperwork has been filed with the Plan Sponsor.

If other dependent coverage does not exist on the day the newborn is born, the appropriate paperwork must be filed within 31 days following birth in order for coverage to be effective on the date of birth.

If both parents of a child are employees of the Plan Sponsor and covered for benefits, either, but not both, may cover the child as a dependent.

A covered person who is eligible as an employee and as a dependent, can be covered under this Plan as both an employee and as a dependent.

SPECIAL ENROLLMENT PERIODS

This Plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of this Plan (or a dependent of such employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage if each of the following conditions is met:

1. The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.
2. The employee stated in writing at the time initial enrollment was offered that other coverage was the reason for declining enrollment in the Plan, but only if the Plan Sponsor required such a statement at such time and provided notice of such requirement (and the consequences of such requirement). NOTE: Your Plan Sponsor reserves the right to request such statement. Please check with your Plan Sponsor to see if such a statement has been imposed.
3. The employee or dependent's coverage was:
   (a) under a COBRA continuation provision and the coverage was exhausted; or
   (b) not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of marriage, legal separation, divorce, death, termination of employment (whether voluntary or involuntary), reduction in the number of hours of employment (whether voluntary or involuntary)), or employer contributions toward such coverage were terminated.
4. Under the terms of this Plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in paragraph 3 above.
5. The employee or dependent has exceeded his lifetime maximum benefit on all benefits under another benefit plan. The request for Special Enrollment must be made within 30 days after the date the benefit maximum has been reached.

In addition to 1 through 5 above, if an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, such employee may be able to enroll himself or herself and any dependents, provided that the request for enrollment is made within 31 days after the marriage, birth, adoption or placement for adoption. Coverage through this special enrollment period is to be retroactive to the date of marriage, birth, adoption or placement for adoption.

Also in addition to 1 through 5 above, if an eligible dependent child between the age of 19 to 23 does not maintain full-time student status or if such child does not enroll for college immediately following high school or does not re-enroll following any semester of college, such child will be ineligible for coverage under this Plan and COBRA Continuation of Benefits will be offered if applicable. If such child later becomes eligible for coverage after becoming a full-time student for the first time (or again if re-enrolling), coverage for such student will become effective on the first day in which school resumes and proof of full-time enrollment is received by the TPA, provided that the request for enrollment is made within 31 days of the student status change.

ELIGIBILITY (cont.)

The individual enrolling for coverage for one of the reasons stated above, will be treated as a new employee (or dependent) under this Plan, however, the waiting period, if any, will be waived for these individuals.

Dependents

If the individual is a participant under the Plan (or has met any waiting period applicable to becoming a participant under the Plan and is eligible to be enrolled under the Plan but for a failure to enroll during a previous enrollment period), AND if a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption, the Plan shall provide for a dependent special enrollment period during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the Plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

A dependent special enrollment period shall be a period of not less than 31 days and shall begin on the later of:

1. The date dependent coverage is made available, or
2. The date of the marriage, birth, or adoption or placement for adoption (as the case may be).

If an individual seeks to enroll a dependent during the first 31 days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

1. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
2. In the case of a dependent's birth, as of the date of such birth; or
3. In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

OPEN ENROLLMENT FOR LATE ENTRANT

Late entrants may enroll for coverage under this Plan during the open enrollment period. The open enrollment period is from August 15th through September 15th with any resultant change in coverage becoming effective on October 1st of the same year. If an employee does not submit a formal written application for coverage under this Plan during the open enrollment period stated, such employee will not be able to enroll until the next annual open enrollment period unless the employee qualifies under this Plan's "Special Enrollment Periods" provision. A late enrollee (or late entrant) no longer has to provide evidence of good health; however, this Plan will apply a pre-existing condition limitation on any pre-existing condition of 18 months (reduced by any periods of prior creditable coverage under Health Insurance Portability and Accountability Act) after an individual's effective open enrollment date.

FAMILY AND MEDICAL LEAVE ACT OF 1993

Under the terms of the Family and Medical Leave Act of 1993, the employer must grant an eligible employee unpaid leave for up to 12 workweeks during any 12 month period. In order for an employee to be eligible, they must have been working for the employer for at least 12 months prior to the leave request and must have worked at least 1,250 hours during that time.

An employee may request leave for any of the following reasons:

1. The birth of a child of the employee to care for the child. This leave entitlement expires 12 months from the birth of the child.
2. The adoption of a child or the placement of a foster child with the employee. This leave entitlement expires 12 months from the birth, adoption or placement of the child.
3. To care for the spouse, child, or parent of the employee if that person has a serious health condition.
4. A serious health condition of the employee that makes the employee unable to perform the duties of his job.

During a period of Family and Medical Leave, the Plan Sponsor must maintain the employee's coverage under any group health Plan, including all Plan changes that occur during the period of Family Medical Leave, on the same conditions as coverage would have been provided if the employee had been continuously employed during the leave.

The Family and Medical Leave Act of 1993 allows the employer to require that an employee's request for leave be supported by a medical certification issued by the health care provider of the employee or of the employee's ill family member. The employer must allow at least 15 calendar days after such request for certification to be provided. If the leave is foreseeable, an employee who fails to provide timely certification may be denied the taking of the leave until the required certification is provided.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

In order to qualify as an "alternate recipient" eligible for benefits under this Plan, courts must have issued a Qualified Medical Child Support Order creating or recognizing the existence of an alternate recipient's rights to receive benefits for which a covered person is eligible under this Plan.

Information provided to the Third Party Administrator, on behalf of the Plan Sponsor, regarding such alternate recipient must clearly specify the following:

1. The name and last known mailing address of the covered person and the name and last known mailing address of each alternate recipient.

ELIGIBILITY (cont.)

2. A reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined.
3. The period for which the Order applies.
4. Each Plan to which the Order applies.

A Plan is not required to provide any type or form of benefit, or any option, not otherwise provided under the Plan except to the extent necessary to meet the requirements of law relating to Qualified Medical Child Support.

Upon receipt of the Order by the Third Party Administrator or Plan Sponsor, the Order will be reviewed to determine that all statutory requirements are met. The Third Party Administrator, on behalf of the Plan Sponsor, will inform the covered person, employer, and the alternate recipient (or the designated registered agent of the alternate recipient) indicating whether or not all statutory requirements have been met. If all statutory requirements have been met, notification of the effective date of coverage for the alternate recipient and a copy of the Plan outlining the coverage provided under this Plan will be sent to the alternate recipient (or designated registered agent of the alternate recipient). Reimbursement of eligible benefits will be made to the covered person, the alternate recipient (or designated registered agent of the alternate recipient), or as otherwise allowed under the terms of this Plan.

If all applicable statutory criteria are not met, the Third Party Administrator, on behalf of the Plan Sponsor, will notify the covered person and the alternate recipient (or designated registered agent of the alternate recipient) indicating why the Order has been denied by the Plan Administrator. The Plan Sponsor will make the final determination as to Plan eligibility under the terms of this Plan.

EFFECTIVE DATES

EMPLOYEE EFFECTIVE DATE - NON-CONTRIBUTORY COVERAGE

If no contributions are required for an employee's class, the effective date of coverage will be the eligibility date provided he meets the active service requirement and has completed an enrollment form. Employees must be properly enrolled for coverage as stated herein.

EMPLOYEE EFFECTIVE DATE - CONTRIBUTORY COVERAGE

If an employee's class requires him to contribute to the cost of his coverage, the effective date will be determined as follows, provided he meets the active service requirement:

1. The eligibility date, provided written application is made on or before the eligibility date.
2. If application for coverage is made within 31 days following eligibility, the effective date will be the date of eligibility.
3. If application for coverage is made more than 31 days after the initial eligibility date for any reason other than one stated in the Special Enrollment Period provision in the Eligibility section, the individual enrolling for coverage will be considered a late entrant (please refer to the Open Enrollment for Late Entrant provision) and will be subject to a pre-existing condition limitation on any pre-existing condition for a period of 18 months, reduced by any prior creditable coverage as provided under the Health Insurance Portability and Accountability Act. The individual will be eligible to re-enroll for coverage only during the open enrollment period stated herein, if any, with any resultant change in coverage becoming effective on the date stated in the open enrollment provision of this document.

DEPENDENT EFFECTIVE DATE - NON-CONTRIBUTORY COVERAGE

If no contributions are required under the Plan for dependent coverage, the effective date of coverage will be the employee's effective date or the dependent's eligibility date, whichever comes second. Dependents must be properly enrolled for coverage as stated herein.

DEPENDENT EFFECTIVE DATE - CONTRIBUTORY COVERAGE

If an employee's Class requires him to contribute to the cost of his dependent's coverage, the effective date will be as follows:

1. The eligibility date, provided written application is made on or before the eligibility date.
2. If application for dependent's coverage is made after the date of eligibility, but on or before the 31st day following eligibility, the effective date will be the date of eligibility.

3. Coverage for a live birth child to a covered employee or dependent spouse shall be effective from and after the moment of birth for covered medical expenses resulting from injury, sickness, premature birth of children under 5½ pounds, congenital conditions, and routine hospital, surgical and medical services provided the appropriate paperwork is filed with the Plan Sponsor within 31 days of birth. If other dependent coverage already exists on the day a newborn is born, coverage for such newborn child will become effective on the date of birth; however, no claims will be processed until the appropriate paperwork has been filed with the Plan Sponsor. If other dependent coverage does not exist on the day the newborn is born, the appropriate paperwork must be filed within 31 days following birth in order for coverage to be effective on the date of birth.
4. If application for coverage is made more than 31 days after the initial eligibility date for any reason other than one stated in the Special Enrollment Period provision in the Eligibility section, the individual enrolling for coverage will be considered a late entrant (please refer to the Open Enrollment for Late Entrant provision) and will be subject to a pre-existing condition limitation on any pre-existing condition for a period of 18 months, reduced by any prior creditable coverage as provided under the Health Insurance Portability and Accountability Act. The individual will be eligible to re-enroll for coverage only during the open enrollment period stated herein, if any, with any resultant change in coverage becoming effective on the date stated in the open enrollment provision of this document.

In no event will coverage for any dependent be effective prior to the employee's effective date.

DEPENDENT BENEFITS

Each employee becomes eligible for dependent benefits on the date the employee is eligible for benefits, if the employee has a dependent. If an employee acquired dependents after his eligibility date, then the employee becomes eligible for dependent coverage on the following dates:

1. The date of marriage;
2. The date of birth of a newborn;
3. The date of legal custody or guardianship; or
4. The date such dependent becomes an alternate recipient eligible for benefits under this Plan as a result of a Qualified Medical Child Support Order.

However, if other dependents exist who are not presently covered under the Plan, those existing dependents, other than those listed above in the Dependent Benefits provision, are only eligible to enroll during the Plan’s open enrollment period (if any) or if such dependent qualifies as a “special enrollee” as stated in the Special Enrollment Period provision of the Eligibility section.

TERMINATION DATES

EMPLOYEE BENEFITS

The coverage of any employee shall automatically cease at the earliest time indicated below: (except as provided in COBRA/Continuation of Benefits provision):

1. Date of termination of his employment;
2. Date employee ceases to be in a class of employees eligible for coverage;
3. Date beginning the period for which the employee fails to make any required contribution for coverage;
4. Date the Plan is terminated; or
5. Date the employee dies.

In the case of absence from work due to leave of absence, continued eligibility of a covered person for all benefits under the Plan, except a weekly income benefit (if any), may be maintained at the discretion of the employer for a period not to exceed 365 calendar days, measured from the first full day of leave. Continued eligibility can continue in the event of a leave of absence beyond the 365 calendar days pursuant to the discretion of the Plan. Such discretion is determined in a uniform non-discriminatory manner. Dependents of such employees on leave of absence that were covered under this Plan on the day before the employee's leave of absence will be eligible for continued coverage during the employee's leave of absence as stated above. Leave of absence due to a health status condition will be administered in accordance with all applicable rules and regulations of the HIPAA Non-Discrimination requirements.

DEPENDENT TERMINATION DATE

The coverage of any covered dependent shall automatically cease at the earliest time indicated below: (except as provided in the COBRA/Continuation of Benefits provision):

1. Date of termination of employee's coverage;
2. Date employee ceases to be in a class of employees eligible for coverage;
3. Date beginning the period that the employee fails to make any required contribution for coverage;
4. Date the Plan is terminated;
5. The first of the month next following the day the employee dies; or
6. Date dependent loses his eligible status, as defined herein. However, coverage of covered dependents under age 23 that are registered students in full-time attendance at a university or similar institution of learning shall cease when the person ceases to be a full-time student. Coverage will terminate on the latest to occur of the following:
   (a.) The date which is the person's last day of full-time attendance.
   (b.) The date which is the last day of a vacation or holiday period following a period of full-time attendance, or
   (c.) The date which is 120 days following completion of a semester or quarter of full-time attendance. If the student turns age 23 during this 120 day period, coverage will cease on the day the dependent attains age 23.

FAMILY AND MEDICAL LEAVE ACT OF 1993

During the period of absence while on Family and Medical Leave, an employee must continue to pay his required share of health coverage premiums in the same manner as before taking family medical leave. The employee's health benefit coverage will cease if the employee's contribution is more than 30 days late. If coverage lapses because an employee has not made required benefit payments, upon the employee's return from Family Medical Leave the employer must still restore the employee to benefits equivalent to those the employee would have had if leave had not been taken and the benefit payments had not been missed.

An employer may recover its share of monies paid towards health plan premiums during a period of unpaid Family Medical Leave from an employee if the employee fails to return to work after the employee's Family Medical Leave Act entitlement has been exhausted or expires, unless the reason the employee does not return is due to the following:

1. The continuation, recurrence, or onset of a serious health condition which would entitle the employee to leave under the Family and Medical Leave Act; or
2. Other circumstances beyond the employee's control.

When an employee fails to return to work because of one or more of the instances stated in numbers 1. and 2. above, the employer may require medical certification of the employee's or the family member's serious health condition. Such certification is not required unless requested by the employer. If the employer requests medical certification and the employee does not provide such certification within 30 days, the employer may recover the health benefit premiums it paid during the period of unpaid Family Medical Leave.

When an employee fails to return to work, except for the reasons stated in numbers 1. and 2. above, health plan premiums paid by the employer during the period of Family and Medical Leave are a debt owed by the non-returning employee to the employer. The existence of this debt caused by the employee's failure to return to work does not alter the Plan Sponsor's responsibilities for coverage and payment of claims incurred during the period of Family and Medical Leave. In circumstances where recovery is allowed, the employer may recover its share of health insurance premiums through deduction from any sums due to the employee (e.g., unpaid wages, vacation pay, profit sharing, etc.) provided such deductions do not otherwise violate applicable Federal or State wage payment or other laws.

In the event that any of the statements contained herein would conflict with the Act or the regulations thereto, only that portion that is not in conformity with the Act would be void and the remainder in full force and effect.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)
CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

This notice contains important information about a covered person's right to COBRA continuation coverage, which is a temporary extension of coverage under the Western Area Schools Association Health Benefit Plan. This notice generally explains COBRA continuation coverage, when it may become available to persons covered under the Plan, and what covered persons need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can, in certain situations described below, become available to covered persons when group health coverage would otherwise be lost. It will also, in certain situations described below, become available to other members of an employee's family who are covered under the Plan when they would otherwise lose group health coverage. This notice gives only a summary of COBRA continuation coverage rights. For more information about a covered person's rights and obligations under the Plan and under federal law, contact the Plan Administrator (employer).

The name and address of the Plan Administrator is stated in the Benefit Plan Summary Description section of the Plan Document/Plan Booklet.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary" and who complies with the requirements set forth herein. A covered employee, covered spouse, and covered dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event and such individuals comply with the requirements set forth herein. A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation of coverage.

Covered employees will become a qualified beneficiary if coverage under the Plan is lost because either one of the following qualifying events happen:

(1) Employee's hours of employment are reduced, or
(2) Employee's employment ends for any reason other than gross misconduct.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)
CONTINUATION COVERAGE RIGHTS UNDER COBRA (cont.)

A covered spouse of an employee will become a qualified beneficiary if coverage is lost under the Plan because any of the following qualifying events happen:

(1) Employee dies;
(2) Employee's hours of employment are reduced;
(3) Employee's employment ends for any reason other than gross misconduct;
(4) Employee becomes entitled to Medicare benefits (under Part A, Part B, or both);or
(5) Employee and spouse become divorced or legally separated.

Covered dependent children will become qualified beneficiaries if coverage is lost under the Plan because any of the following qualifying events happen:

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than gross misconduct;
(4) The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
(5) The parents become divorced or legally separated; or
(6) The child stops being eligible for coverage under the Plan as a "dependent child".

If retiree coverage is offered, sometimes filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Western Area School Association, and that bankruptcy results in the loss or substantial elimination of coverage of any retired employee covered under the Plan (either 12 months before or after the bankruptcy filing), the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if the bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries after the Plan Administrator has been notified and determines that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer (with regard to retirees and their covered spouse and dependents only and only if retiree coverage is available), or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

QUALIFIED BENEFICIARIES MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and covered spouse or a covered dependent child's losing eligibility for coverage under the Plan as a dependent child), the Plan Administrator must be notified of the qualifying event. The Plan requires notice to the Plan Administrator within 60 days after the qualifying event occurs. This notice must be sent to the Employer, attention Human Resources Department. Failure to notify the Plan Administrator of these qualifying events in a timely manner will result in ineligibility for COBRA continuation coverage.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their eligible spouse, and parents may elect COBRA continuation coverage on behalf of their eligible children.

COBRA continuation coverage is a temporary continuation coverage. When the qualifying event is the death of the employee, entitlement of the employee to Medicare benefits (under Part A, Part B, or both), employee and spouse divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage may last for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee, may last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which employment terminates, COBRA continuation coverage for spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight (8) months). Otherwise, when the qualifying event is the end of employment or reduction of employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two (2) ways in which this 18-month period of COBRA continuation can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If a person covered under the Plan is determined by the Social Security Administration to be disabled at or within the first 60 days of COBRA continuation coverage the Plan Administrator is notified in writing of the determination within 60 days of its receipt and prior to the end of the 18-month continuation period, persons covered can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH CONTINUATION COVERAGE

If a family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in the family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan in writing within 60 days of the second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Note: In most cases, a former employee's entitlement to Medicare that occurs after the first qualifying event will not extend the COBRA time period for spouses and dependents because had the first qualifying event not occurred and the former employee was still an active worker, entitlement to Medicare would not result in a loss of family coverage under the Plan.

EARLY TERMINATION OF COBRA COVERAGE

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a covered employee becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

HOW TO ELECT COBRA COVERAGE

If a covered person is eligible for COBRA after a qualifying event, the Plan Administrator (or TPA on behalf of the Plan Administrator {if mutually agreed upon and included in the Administrative Services Agreement}) will send a COBRA Election Form after it has been notified of a covered person's eligibility. To elect continuation coverage, the Election Form must be completed and furnished according to the directions on the Form and the requirements set forth therein. Each qualified beneficiary has a separate right to elect (or decline) continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect (or decline) continuation coverage on behalf of all the qualified beneficiaries.

In considering whether to elect continuation coverage, it should be taken into account that a failure to continue group health coverage will affect a person's future rights under federal law. First, a person can lose the right to avoid having pre-existing condition exclusions applied to them by other group health plans if there is more than a 63-day gap in health coverage, and election of continuation coverage may help a person not have such a gap. Second, a person will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if a person does not get continuation coverage for the maximum time available to them. Finally, covered persons should take into account that they may have special enrollment rights under federal law. A covered person may have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after group health coverage ends because of the qualifying event listed above. A covered person may also have the same special enrollment right at the end of continuation coverage if a covered person gets continuation coverage for the maximum time available to them.

If a covered person does not return the Election Form by the time specified therein, it is presumed that such person(s) have chosen to decline COBRA continuation coverage.

HOW MUCH DOES COBRA CONTINUATION COVERAGE COST?

Generally, each qualified beneficiary will be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). This section only applies to such eligible persons. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. Questions about these new tax provisions can be directed to the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.cfm.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)
CONTINUATION COVERAGE RIGHTS UNDER COBRA (cont.)

WHEN AND HOW MUST PAYMENT BE MADE?

First payment for continuation coverage

If continuation coverage is elected, a covered person may, but does not have to, send payment with the Election Form. However, the first payment must be made for continuation coverage not later than 45 days after the date of the election. (This is the date the Election Notice is postmarked, if mailed.) In other words, the first payment must cover all elapsed months of COBRA coverage as of the time payment is made. If the first payment for continuation coverage is not paid in full not later than 45 days after the date of continuation coverage election, all continuation coverage rights under the Plan will be lost.

Periodic payments for continuation coverage

After first payment for continuation coverage is made, qualified beneficiary(ies) will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary will be provided with the Election Form. The periodic payments must be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the date stated on the Election Form for that coverage period. If a periodic payment is made on or before the first day of the coverage period to which it applies, coverage under the Plan will continue for that coverage period without any break. The plan, depending on its procedures, may or may not send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due as described above, qualified beneficiary(ies) will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. A Plan, depending on its procedures, may or may not suspend coverage during grace period for non-payment. However, if a periodic payment is made later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

If a qualified beneficiary fails to make a periodic payment before the end of the grace period for that coverage period, all rights to continuation coverage under the Plan will be lost.

QUESTIONS ABOUT CONTINUATION COVERAGE

Questions about the Plan or COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about rights under ERISA, if any, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and any other laws affecting group health plans, contact the nearest Regional or District office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at *www.dol.gov/ebsa*. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website).

KEEP THE PLAN INFORMED OF ADDRESS CHANGES

In order to protect a qualified beneficiaries rights, a qualified beneficiary should keep the Plan Administrator informed of any changes in the addresses of family members. Qualified beneficiaries should also keep a copy, for their records, of any notices sent to the Plan Administrator.

PLAN CONTACT INFORMATION

Contact the Plan Administrator at the address provided in the Benefit Plan Summary Description section of the Plan Document/Plan Booklet to request information about the Plan, including but not limited to, COBRA continuation coverage.

NOTE

This General Notice does not fully describe continuation coverage or other rights under the Plan. More complete information regarding such rights are available by contacting the Plan Administrator.

UNIFORMED SERVICES ACT

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), continuation coverage under the Plan is available to covered persons 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 COBRA Continuation of Benefits as described herein.

If an employee fails to work the minimum hourly requirement in order to be eligible for benefits as stated herein for more than 31 days because of duty in the uniformed services, such employee and eligible covered dependents will be entitled to elect continuation coverage the same as if such employee had experienced one of the Qualifying Events in the COBRA Continuation of Benefits Section and COBRA rates can be applied to the covered person(s) during this time. However, this extended coverage will last no more than 24 months (or the maximum allowed under USERRA) and cannot be extended regardless of the occurrence of such event unless otherwise permissible under State law.

For military service of less than 31 days, health care coverage is provided as if the covered person had never left for military duty.

CONTINUATION OF COVERAGE UNDER ILLINOIS MUNICIPAL RETIREMENT FUND (IMRF)

Each employer shall offer on behalf of the Plan continuation benefits to each covered person who is a participant in the Illinois Municipal Retirement Fund (IMRF) whose coverage under the Plan would otherwise terminate due to his termination of employment. Continuation coverage pursuant to this section shall be available only to eligible IMRF participants and during the retirement or disability period as defined below. Eligible dependents of an IMRF employee shall be eligible for coverage in the same manner and under the same conditions as apply to other covered persons.

As used in this section, Retirement or Disability Period refers to the period of time:

(A) which begins on the day the IMRF employee is removed from the employer's payroll because of the occurrence of either of the following events:

1. The IMRF Employee retires from active service as an employee with an attained age and accumulated creditable service which together qualify the IMRF employee for immediate receipt of retirement pension benefits under the IMRF, or
2. The IMRF employee's disability is established under IMRF; and

(B) which ends on the first to occur of any of the following events:

1. The IMRF employee's reinstatement or re-entry into active service as provided for under the rules of IMRF,
2. The IMRF employee's exercise of any refund option or acceptance of any separation benefit available under IMRF,
3. The IMRF employee's loss of IMRF benefits as a result of a felony conviction in accordance with 40 ILCS 5/7-219,
4. The IMRF employee's death, or if at the time of the IMRF employee's death, the IMRF employee is survived by a spouse who, in that capacity, is entitled to receive a surviving spouse monthly pension benefit under IMRF, the death or remarriage of that spouse,
5. The employer terminates health insurance coverage for all employees (actives and those covered under the Plan), or
6. The IMRF employee's failure to pay any required contribution for coverage.

Upon receipt of notification of the intent of an IMRF employee to elect continuation coverage, the Plan Sponsor shall notify the IMRF employee of the election procedure and provide the necessary forms to make the election. The Plan Sponsor shall also provide a calculation of the cost to the IMRF employee of maintaining the continuation coverage.

The covered person and/or his covered dependents is required to pay the entire cost of such continuation coverage computed at the same rate charged for equivalent coverage provided under the Plan with respect to covered persons and/or covered dependents whose retirement or disability period has not begun.

Continuation of benefits in accordance with this section shall be coordinated with, and are not in addition to, continuation of benefits available pursuant to any other section of this Plan.

CALL 800-ASK-IMRF to determine IMRF eligibility and for further IMRF questions.

VICTIMS' ECONOMIC SECURITY AND SAFETY ACT

I. ENTITLEMENT TO LEAVE DUE TO DOMESTIC OR SEXUAL VIOLENCE

An employee who is a victim of domestic or sexual violence or has a family or household member who is a victim of domestic or sexual violence whose interests are not adverse to the employee as it relates to the domestic or sexual violence, may take unpaid leave from work to address domestic or sexual violence by:

1. Seeking medical attention for, or recovering from, physical or psychological injuries caused by domestic or sexual violence to the employee or the employee's family or household member;
2. Obtaining services from a victim services organization for the employee or the employee's family or household member;
3. Obtaining psychological or other counseling for the employee or the employee's family or household member;
4. Participating in safety planning, temporarily or permanently relocating, or taking other actions to increase the safety of the employee or the employee's family or household member from future domestic or sexual violence or ensure economic security; or
5. Seeking legal assistance or remedies to ensure the health and safety of the employee or the employee's family or household member, including preparing for or participating in any civil or criminal legal proceeding related to or derived from domestic or sexual violence;

An employee shall be entitled to a total of 12 workweeks of leave during any 12-month period. This Act does not create a right for an employee to take unpaid leave that exceeds the unpaid leave time allowed under, or in addition to the unpaid leave time permitted by, the federal Family and Medical Leave Act of 1993.

Leave described above may be taken intermittently or on a reduced work schedule.

II. NOTICE

The employee shall provide the employer with at least 48 hours advance notice of the employee's intention to take the leave, unless providing such notice is not practicable. When an unscheduled absence occurs, the employer may not take any action against the employee if the employee, within a reasonable period after the absence, provides certification as stated below.

III..CERTIFICATION

1. The employer may require the employee to provide certification to the employer that:

   A. The employee or the employee's family or household member is a victim of domestic or sexual violence; and
   B. The leave is for one of the purposes stated in Section I.

   The employee shall provide such certification to the employer within a reasonable period after the employer requests the certification.

2. An employee may satisfy the certification requirement stated herein by providing to the employer a sworn statement of the employee, and upon obtaining such documents the employee shall provide:

   A. Documentation from an employee, agent, or volunteer of a victim services organization, an attorney, a member of the clergy, or a medical or other professional from whom the employee or the employee's family or household member has sought assistance in addressing domestic or sexual violence and the effects of the violence;
   B. A police or court record; or
   C. Other corroborating evidence.

IV. CONFIDENTIALITY

All information provided to the employer including a statement of the employee or any other documentation, record or corroborating evidence, and the fact that the employee has requested or obtained leave pursuant to this Section, shall be retained in the strictest confidence by the employer except to the extent that disclosure is:

1. Requested or consented to in writing by the employee; or
2. Otherwise required by applicable federal or State law.

V. EMPLOYMENT AND BENEFITS

1. Restoration to position

   A. Any employee who takes leave under this Section for the intended purpose of the leave shall be entitled, on return from such leave:
      (i) To be restored by the employer to the position of employment held by the employee when the leave commenced; or
      (ii) To be restored to an equivalent position with equivalent employment benefits, pay, and other terms and conditions of employment.

   B. The taking of leave under this Section shall not result in the loss of any employment benefit accrued prior to the date on which the leave commenced.

   C. Nothing in this subsection shall be construed to entitle any restored employee to:
      (i) The accrual of any seniority or employment benefits during any period of leave; or
      (ii) Any right, benefit, or position of employment other than any right, benefit, or position to which the employee would have been entitled had the employee not taken the leave.

   D. Nothing in this paragraph shall be construed to prohibit an employer from requiring an employee on leave under this Section to report periodically to the employer on the status and intention of the employee to return to work.

2. Maintenance of health benefits

   A. Except as provided in subparagraph (B) below, during any period that an employee takes leave under this Section, the employer shall maintain coverage for the employee and any family or household member under any group health plan for the duration of such leave at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of such leave.

   B. The employer may recover the premium that the employer paid for maintaining coverage for the employee and the employee's family or household member under such group health plan during any period of leave under this Section if:
      (i) The employee fails to return from leave under this Section after the period of leave to which the employee is entitled has expired; and
      (ii) The employee fails to return to work for reasons other than:
         (I) The continuation, recurrence, or onset of domestic or sexual violence that entitles the employee to leave pursuant to this Section; or
         (II) Other circumstances beyond the control of the employee.

C. An employer may require an employee who claims that the employee is unable to return to work because of a reason described in sub-clause (I) or (II) of subparagraph (B) (ii) to provide, within a reasonable period after making the claim, certification to the employer that the employee is unable to return to work because of that reason.
   (i) An employee may satisfy the certification requirement by providing to the employer:
      (I) A sworn statement of the employee;
      (II) Documentation from an employee, agent, or volunteer of a victim services organization, an attorney, a member of the clergy, or a medical or other professional from whom the employee has sought assistance in addressing domestic or sexual violence and the effects of that violence.
      (III) A police or court record; or
      (IV) Other corroborating evidence.

D. All information provided to the employer, including a statement of the employee or any other documentation, record, or corroborating evidence, and the fact that the employee is not returning to work because of a reason described above shall be retained in the strictest confidence by the employer, except to the extent that discourse is:
   (i) Requested or consented to in writing by the employee; or
   (ii) Otherwise required by applicable federal or State law.

VI. ENFORCEMENT

1. Any employee or a representative of employees who believes his or her rights under this Act have been violated may, within three (3) years after the alleged violation occurs, file a complaint with the Department of Labor requesting a review of the alleged violation. A copy of the complaint shall be sent to the person who allegedly committed the violation, who shall be the respondent. If the Department of Labor finds that a violation did occur, the Department shall issue a decision incorporating such findings and requiring the party committing the violation to take such affirmative action to abate the violation as the Department of Labor deems appropriate, including:

   A. Damages equal to the amount of wages, salary, employment benefits, public assistance, or other compensation denied or lost to such individual by reason of the violation, and the interest on that amount calculated at the prevailing rate.
   B. Such equitable relief as may be appropriate, including but not limited to hiring, reinstatement, promotion, and reasonable accommodations; and
   C. Reasonable attorney's fees, reasonable expert witness fees and other costs of the action to be paid by the respondent to a prevailing employee.

   If the Department of Labor finds that there was no violation, he or she shall issue an order denying the complaint. An order issued by the Department of Labor under this Section shall be final and subject to judicial review under the Administrative Review Law.

2. The Department of Labor shall adopt rules necessary to administer and enforce this Act in accordance with the Illinois Administrative Procedure Act. The Department shall have the powers and the parties shall have the rights provided in the Illinois Administrative Procedure Act for contested cases, including, but not limited to, provisions for depositions, subpoena power and procedures, and discovery and protective order procedures.
3. The Attorney General of Illinois may intervene on behalf of the Department if the Department certifies that the case is of general public importance. Upon such intervention the court may award such relief as authorized to be granted to an employee who has filed a complaint or whose representative has filed a complaint under this Section.
4. Any employer who has been ordered by the Department of Labor or the court to pay damages under this Section and who fails to do so within 30 days after the order is entered is liable to pay a penalty of 1% per calendar day to the employee for each day of delay in paying the damages to the employee.

VII. NOTIFICATION

Every employer covered by this Act shall post and keep posted, in a conspicuous place on the premises of the employer where notices to employees are customarily posted, a notice, to be prepared or approved by the Department of Labor, summarizing the requirements of this Act and information pertaining to the filing of a charge. The Department of Labor shall furnish copies of summaries and rules to employers upon request without charge.

VIII. EFFECT ON OTHER LAWS AND EMPLOYMENT BENEFITS

1. Nothing in this Act shall be construed to supersede any provision of any federal, State, or local law, collective bargaining agreement, or employment benefits program or plan that provides:
   A. Greater leave benefits for victims of domestic or sexual violence than the rights established under this Act; or
   B. Leave benefits for a larger population of victims or domestic or sexual violence (as defined in such law, agreement, program, or plan) than the victims of domestic or sexual violence covered under this Act.
2. The rights established for employees who are victims of domestic or sexual violence and employees with a family or household member who is a victim of domestic or sexual violence under this Act shall not be diminished by any federal, State or local law, collective bargaining agreement, or employment benefits program or plan.

IX. SEVERABILITY

If any provision of this Act or the application of such provision to any person or circumstance is held to be in violation of the United States Constitution, the remainder of the provisions of this Act and the application of those provisions to any person or circumstance shall not be affected.

The information contained herein is only a summary of the Victims' Economic Security and Safety Act, Public Act 93-0591.

COVERAGE FOR CERTAIN INCAPACITATED CHILDREN

Dependent benefits under this Plan for an unmarried dependent child may be continued, beyond the date the child attains the limiting age for dependent coverage, if all the following requirements are met:

1. The child, on the date he attains the limiting age, is incapable of self-sustaining employment because of mental retardation or physical handicap and became so incapacitated prior to attainment of the limiting age; and
2. The child, on the date he attains the limiting age, is chiefly dependent on the covered person for support;
3. The child was a covered dependent under this Plan on the day immediately prior to the attainment.

However, dependent benefits as to the child may not be continued beyond the earliest of the following occurrences, except as specified under COBRA:

1. Employee termination under the Plan;
2. Cessation of the incapacity;
3. Failure to furnish any required proof of continuing incapacity or to submit to any required examination;
4. Termination of dependent coverage for any reason other than attaining the limiting age;
5. Termination of dependent benefits under this Plan; or
6. Date at the end of a period for which required contributions have not been made.

The Plan Sponsor shall require due proof of the continuation of the incapacity and shall examine the child whenever it may reasonably require during the continuation of the incapacity. However, an examination will not be required more often than once a year after two (2) years have elapsed from the date the child attained the limiting age.

COORDINATION OF BENEFITS PROVISION

To coordinate benefits, it is necessary to determine in what order the benefits of various plans are payable. This is determined as follows:

1. If a plan does not have a provision for the coordination of benefits, its benefits are payable before those of a plan that does have a Coordination of Benefits provision.
2. If a plan covers a person other than as a dependent, its benefits are payable before those of a plan that covers this person as a dependent.
3. When parents are married, a plan which covers an individual as the dependent of an employee whose birthday (excluding year of birth) occurs earlier in a calendar year, pays first. If the other plan does not have this rule, and if, as a result the plans do not agree, this rule can be waived. However, when parents are divorced or legally separated, a copy of the divorce decree, or legal document, must be provided and the parent legally deemed responsible for health coverage will be primary. If the legal document does not specify health coverage responsibility, the primary plan will be in the order as follows:
   a) Parent with custody
   b) Step-Parent with custody
   c) Legal Parent without custody
4. If items 1, 2 or 3 do not apply, the benefits of a plan that has covered the person for the longest period of time will be payable before those of the other plan.
5. The benefits of a plan that covers a person as a laid-off employee, retired employee, a dependent of such person, or COBRA Participant, will be determined after the benefits of any other plan covering the person as an employee or a dependent of such person. However, if the other plan does not have this rule, and if as a result, the plans do not agree, this rule can be waived.

If the eligible employee or any eligible dependent has duplicate coverage under any other group plan, the benefits payable by this Plan will be adjusted if the other group plan's benefits, plus this Plan's benefits, exceed 100% of the eligible charges. This is done so that benefits payable from all sources, including government-sponsored plans, do not exceed 100% of the eligible charges incurred.

To administer this provision, the Plan Sponsor and the Third Party Administrator have the right to:

1. Give or get data needed to determine the benefits payable under this provision;
2. Recover any sum paid above the amount that is allowed under this provision;
3. Repay any party for a payment made by the party, when the payment should have been made by the employer.

COORDINATION OF BENEFITS PROVISION (cont.)

Dissimilar Plans

The Coordination of Benefits procedure in this Plan will be further modified as provided in this section if the following conditions exist:

a.) For the covered dependent for whom this Plan coordinates benefits, and there are one or more plans (other than this Plan) from which to choose to be his primary plan;
b.) A plan is selected as the primary plan which is not the most valuable plan (the most valuable plan being the one that provides the most benefits that are available under the Plan in its entirety);
c.) The plan selected as the primary plan is less valuable than the benefits that would be provided under this Plan coordinating as the secondary plan.

If all these conditions are met, then the Dissimilar Plans criteria has been met. As such, obligations of this Plan to provide benefits for expenses incurred but for which benefits were not paid by the primary plan is limited, and this Plan, the secondary plan, will coordinate coverage as the secondary plan using its own benefit plan as the primary plan but considering benefits for claim payment purposes, solely as though it is the secondary plan. For the purposes of administering this provision, this Plan will consider benefits as though it is the primary plan; however, this Plan will pay only the difference that is payable as a secondary plan assuming that the secondary plan has identical benefits to this Plan.

Information necessary to administration of this Dissimilar Plans provision will be required at the time a claim is submitted.

MEDICARE BENEFITS

Under federal legislation, the Tax Equity and Fiscal Responsibility Act of 1982, the Deficit Reduction Act of 1984 and the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, employees in active service ages 65 and over, and dependent spouses ages 65 and over of employees in active service, will continue this program of health benefits. Medical benefits payable under this plan for such persons shall be the same as the benefits for covered persons who are under age 65.

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

GENERAL PROVISIONS

ACCIDENTS AT WORK: Health benefits are not payable for injuries or illness for which a covered person is entitled to indemnity or compensation by any Workers' Compensation Act, or like program.

ASSIGNMENT OF BENEFITS: The Plan Sponsor reserves the right to accept or decline an assignment of benefits.

CHANGE OR DISCONTINUANCE: The employer may, at any time, change or discontinue the benefits provided in this Plan Document/Plan Booklet, but no change or discontinuance may affect, in any way, the amount or the terms of any benefits payable under this Plan Document/Plan Booklet prior to the date of such change or discontinuance. Any change will be subject to the non-confinement rule, as stated in the Effective Dates provision, for a covered person.

CLAIM DETERMINATIONS: The claim procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with the governing Plan Document and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants.

CLAIM PROCEDURES: The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, in the case of a claim involving urgent care, a health professional with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant.

CLERICAL ERROR: Any clerical error (by the Plan Sponsor or the Third Party Administrator) in keeping pertinent records or a delay in making any entry, will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered. The Plan Sponsor reserves the right to recover any overpayment, duplicate payment, excess payment or payment made in error from any person or entity to whom, for whom, or with respect to whom payment was made.

COMPLIANCE: The Plan shall comply with all applicable federally mandated benefit laws and regulations pertaining to employee benefit plans. Notwithstanding the intent of the Plan to assure full compliance with appropriate federal laws, rules and regulations, no commission of error(s) through negligence, or error which results in any such violation, shall be construed as malintent in the sole remedy for any error of omission or commission will be corrective action and specifically limited therein.

CONCURRENT CARE DECISIONS: If a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, (1) Any reduction or termination by the Plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The TPA shall notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated; (2) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the TPA shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

CONTRIBUTIONS: Contributions, when required, are payable as specified by the Plan Sponsor. Any coverage becoming effective will be charged from the first day of the calendar month coinciding with or next following the date the coverage takes effect, and contributions for coverage that has been terminated will cease as stated in the Termination Dates provision.

DATA REQUIRED: The Plan Administrator must furnish the Third Party Administrator with all information the Third Party Administrator reasonably requires as to matters pertaining to this Plan. All material which may have a bearing on coverage or contributions will be open for inspection by the Third Party Administrator at all reasonable times during the continuance of this Plan and until the final determination of all rights and obligations under this Plan.

DISCRETIONARY AUTHORITY: The Plan Sponsor has the Discretionary Authority to make certain determinations under the Plan, and the Plan's Sponsor's determination under the Plan will be final and binding.

ERISA AMENDMENTS: Any provision of the Plan that is in conflict with ERISA, which governs this Plan, shall be deemed amended to conform with the minimum requirements of the law. Even though this Plan is exempt from some or all of ERISA's provisions, it operates under the assumption of an ERISA Plan with some exceptions.

FACILITY OF PAYMENT: If any covered person, in the opinion of the Plan Administrator, is legally incapable of giving a valid receipt for any payment due him and no guardian has been appointed, the Plan Administrator may, at its option, make such payment to the individual or individuals as have, in the Plan Administrator's opinion, assumed the care and principal support of such covered person. If the covered person should die before all amounts due and payable to him have been paid, the Third Party Administrator may, at its option, make such payment to the executor or administrator of his estate or to his surviving wife, husband, mother, father, child or children, or to any other individual or individuals who are equitably entitled thereto.

Any payment made by the Plan Administrator in accordance with these provisions shall fully discharge the Plan to the extent of such payment.

GENERAL PROVISIONS (cont.)

LIENS: To the full extent permitted by law, all rights and benefits accruing under this Plan shall be exempt from execution, attachment, garnishment, or other legal or equitable process for the debts or liabilities of any employee.

This Plan is not a substitute for and does not affect any requirements for coverage by Workers' Compensation Act, or like program.

MISCELLANEOUS: A failure to enforce any provisions of this Plan shall not affect any right thereafter to enforce any such provision, nor shall such failure affect any right to enforce any other provision of this Plan.

MISSTATEMENTS: If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, coverage can be rescinded and an equitable adjustment of contributions will be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under this Plan and its amount.

NOTICE AND PROOF OF CLAIMS: The payment of any benefit set forth in this Plan Document/Plan Booklet is subject to the provision that the covered person furnish such proof and any releases that the Plan Administrator may reasonably require before approving the payment of such benefit.

Proof of loss must be furnished to the Third Party Administrator, not later than one (1) year after the loss. Claims that are not submitted to the Third Party Administrator within the time frame stated, will be denied. If it is not reasonably possible to furnish such notice within the time specified, it will not invalidate or reduce the claim payment.

How to File a Claim:

1. Obtain a claim form from your employer. Complete the claim form, making sure that you include your employee identification number (as shown on your ID card) and group number (as shown on your ID card and in the Claim Filing Information section).
2. The original itemized bill for services (not copies or faxed copies) may be attached to the claim form. Each bill must show a description of services rendered, the cost of each service, the date the service was performed and the diagnosis for treatment.
3. If the covered person is covered under another group insurance plan that is primary, the claim must be filed under the primary plan first. The covered person then may file a claim under this Plan, and attach a copy of the primary plan's Explanation of Benefits and a copy of itemized bills.
4. After completing the claim form, mail it to the address stated in the Claim Filing Information section.

No action at law or in equity may be brought to recover on this Plan after three (3) years from the time written notice is required to be furnished.

The Plan Administrator shall have the right and opportunity to have a physician, designated by the Plan Administrator, to examine the individual whose injury or sickness is the basis of claim when and so often as it may reasonably require during the pendency of claim hereunder.

APPEAL PROCESS

If upon application of benefits under this Plan, it is determined that the benefit shall be wholly or partially denied (resulting in an Adverse Benefit Determination) based on the terms and provisions of the Plan, written notice of the adverse benefit determination shall be furnished to the claimant on the Explanation of Benefits (EOB). Upon the claimant's request, relevant protocols (documents, records, etc.) used in making the adverse benefit determination will be made available at no charge to the claimant.

Upon the claimant's receipt of the written notice of the adverse benefit determination, the claimant has 180 days to file a written request with the TPA (on behalf of the Plan Sponsor) that a full and fair review of such claim be conducted (appeal). (NOTE: Urgent care claim appeals may be accepted orally by contacting the TPA's Benefit's Claims Supervisor).

The TPA shall notify the claimant of the Plan's benefit determination and appeal as follows:

- Urgent Care Claims: As soon as possible taking into account the medical exigencies, but no later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the Plan
- Pre-Service Claims: The TPA shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that provides for one (1) appeal of an adverse benefit determination, such notification shall be provided no later than 30 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two (2) appeals on an adverse benefit determination, such notification shall be provided, with respect to any one (1) of such two (2) appeals, no later than 15 days after receipt by the Plan of the claimant's request for review of the adverse benefit determination.
- Post-Service Claims: The TPA shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time. In the case of a group health plan that provides for one (1) appeal of an adverse benefit determination, such notification shall be provided no later than 60 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two (2) appeals of an adverse determination, such notification shall be provided, with respect to any one (1) of such two (2) appeals, no later than 30 days after receipt by the Plan of the claimant's request for review of the adverse determination.

Levels of Appeal

Level I Standard Appeals can result from: (1) An expedited appeal that did not reverse the initial decision to not pay the claim in full, or (2) Denial based on lack of medical necessity from a pre-certification or retrospective review. Level I Standard Appeals based on a Plan Document determination are conducted by an individual that is neither the party who made the initial adverse benefit determination, nor the subordinate to such party. Adverse benefit determinations based on a medical decision will be conducted by a medical professional and/or physician in the same or similar specialty as the treating physician who was not previously involved in the case.

Level II Final Appeals are available when a Level I Standard Appeal does not result in a reversal of the initial adverse benefit determination. The claimant may request a Level II Final Appeal within 180 days of the Level I Standard Appeal. Level II Final Appeals will be completed by an individual in the same or similar specialty who was not previously involved in the case.

If more than one (1) level of appeal takes place, both levels must be completed within the time-frame applicable to one level (i.e., both levels of appeal must be decided within 72 hours for urgent care appeals; 30 days for non-urgent, pre-service claims; and 60 days for post service claims).

VOLUNTARY LEVELS OF ARBITRATION

To the extent that a plan offers voluntary levels of appeal, including voluntary arbitration or other form of dispute resolution, the claims procedures provide that: (1) The Plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the Plan; (2) The Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending; (3) The claims procedures provide that a claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted; (4) The plan provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the Plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and (5) No fees or costs are imposed on the claimant as part of the voluntary level of appeal.

GENERAL PROVISIONS (cont.)

OLD CHECKS: The Plan reserves the right to dishonor checks issued for benefit payments that are not presented for payment within 180 days of the date of issuance.

PLAN: All statements made by the Third Party Administrator or its employees or the Plan Administrator or its employees shall be deemed representations and not warranties. No written statement made by a primary covered person shall be used by the Plan Administrator in a contest unless a copy of the instrument containing the statement is or has been, furnished to the primary covered person, his beneficiary, or the person making the claim.

Except as to a fraudulent misstatement, no statement made by the Plan Administrator or any employee shall void any coverage, reduce any benefits, or be used in defense of a claim unless it is in writing.

REIMBURSEMENT PROVISION: If a covered individual is injured through the act or omission of another person, the benefits of this Plan shall be provided only if the primary covered person shall provide an Equitable Trust Agreement in writing. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine acceptability of any applicant for participation in the Plan.

TERMINATION OF THE PLAN OR COVERAGE: This Plan shall continue in effect until terminated by the Plan Sponsor pursuant to the terms of this section.

The Plan Sponsor has reserved the right to modify, revoke, suspend, change or terminate the Plan and any coverage effective under this Plan, at any time by written notice, without the consent of any person.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

BENEFITS SUBJECT TO THIS PROVISION

This provision shall apply to all benefits provided under any section of this Plan.

WHEN THIS PROVISION APPLIES

A covered person may incur medical or other charges related to Injuries or Illness for which benefits are paid by the Plan. The Injuries or Illness may be caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of any charges incurred in connection with the Injuries or Illness. If so, the covered person may have a claim against that other person or a third party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be subrogated to all rights the covered person may have against that other person or third party and will be entitled to Reimbursement. In addition, the Plan shall have an equitable lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The covered person agrees that acceptance of benefits under the Plan is constructive notice of this provision.

As a condition to receiving benefits under the Plan, the covered person must:

1. Assign and subrogate to the Plan his rights to recovery when this provision applies;
2. Authorize the Plan to sue, compromise and settle in the covered person's name to the extent of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount;
3. Immediately reimburse the Plan out of the Recovery made from the other person, the other person's insurer or the third party, 100% of the amount of medical or other benefits paid for the Injuries under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);
4. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, the covered person and his attorney will execute and deliver all required instruments and papers, including a subrogation agreement/equitable trust agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Illness. The Plan has no obligation to pay any medical or other benefits for the Injuries or Illness before these papers are signed and things are done; however, in the event the Plan does so, the Plan will still be entitled to Subrogation and Reimbursement. In addition, the covered person will do nothing, and will not permit his attorney to do anything, to prejudice the right of the Plan to subrogate

and be reimbursed and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines. If the covered person retains an attorney, the covered person agrees to only retain one who will not assert the common-fund or made-whole doctrines. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

In the event the covered person fails to institute a proceeding against such First Party or Third Party at any time prior to three (3) months before such action would be legally barred by any applicable Statute of Limitations, the Plan may in its own name or in the name of the covered person, commence a proceeding against such First Party or Third Party. The Plan will pay over to the covered person or his personal representatives all sums collected from such Third Party by judgment or otherwise that are in excess of the amount of such benefits paid or to be paid under this Plan, including costs, attorney's fees and reasonable expenses as may be incurred by the Plan in making such collection.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

AMOUNT SUBJECT TO SUBROGATION OR REIMBURSEMENT

All amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise, even if the covered person does not receive full compensation for all of his charges and expenses.

ANOTHER PARTY

"Another Party" shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a covered person's Injuries or Illness.

"Another Party" shall include the party or parties who caused the Injuries or Illness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a covered person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Illness.

The benefits payable under this Plan will be excess in all instances when another Plan claims to be excess over any other valid and collectable insurance including but not limited to: automobile uninsured or underinsured coverage (or any other automobile coverage that reimburses medical payments; homeowner's/renters medical payment coverage; indemnity plan payments; or hospital indemnity plan).

If any of the other coverages available to the covered person provide for the same excess provision, this Plan will pay on a pro rata basis, or an amount mutually agreed upon by both parties.

RECOVERY

"Recovery" shall mean any and all monies paid to the covered person by way of judgment, settlement, or otherwise (and no matter how those monies may be characterized or designated) to compensate for all losses caused by, or in connection with, the Injuries or Illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

SUBROGATION

"Subrogation" shall mean the Plan's right to pursue the covered person's claims for medical or other charges paid by the Plan against the other person, the other person's insurer and the third party.

REIMBURSEMENT

"Reimbursement" shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Illness and for the expenses incurred by the Plan in collecting this benefit amount.

WHEN THE COVERED PERSON IS A MINOR OR IS DECEASED

These provisions apply to the parents, trustee, guardian or other representative of a minor covered person and to the personal representative of the estate of a deceased covered person, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

WHEN A COVERED PERSON DOES NOT COMPLY

When a covered person does not comply with the provisions of this Section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the covered person and to reduce future benefits payable under the Plan by the amount due as Reimbursement to the Plan. If the Plan must bring an action against a covered person to enforce this provision, then that covered person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

STATEMENT OF EMPLOYEE RIGHTS

As a covered person of the Employee Group Health Plan, an employee is entitled to certain rights and protections. Covered persons shall be entitled to:

1. Examine without charge, at the Third Party Administrator's office or the Plan Sponsor's office, and at other locations during normal business hours, all Plan Documents, including insurance.
2. Obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each covered person with a copy of this summary financial report.
4. Continue health care coverage for the covered employee and any eligible dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Covered persons may have to pay for such coverage. Please refer to the COBRA Continuation of Benefits section.
5. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under this Plan if a person has prior creditable coverage from another plan. Persons should be provided a certificate of creditable coverage, free of charge, from the group health plan or insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases (if requested before losing coverage), or if a person requests a certificate up to 24 months after losing coverage. Without evidence of creditable coverage, persons may be subject to a pre-existing condition exclusion as stated in the Pre-Existing Condition Limitation section.
6. File suit in Federal court, if any materials requested are not received within 30 days of the covered person's request, unless the materials were not sent because of matters beyond the control of the Plan Administrator. The court may require the Plan Administrator pay up to $110 for each day's delay until the materials are received.

There are obligations upon the persons who are responsible for the operation of the Employee Benefit Plan. The persons are referred to as "fiduciaries" in the law. Fiduciaries must act solely in the interest of the covered persons and they must exercise prudence in the performance of the Plan duties.

An employer may not fire or discriminate against an employee to prevent him from obtaining a (welfare) benefit or exercising his rights as stated herein.

If an employee is improperly denied a (welfare) benefit in full or in part, he has a right to file suit in Federal or State court. If Plan fiduciaries are misusing the Plan's money, an employee has a right to file suit in Federal court. If he is successful in his lawsuit, the court may, if it so decides, require the other party to pay his legal costs, including attorney's fees. If the employee is unsuccessful, the court may, if it so decides, order him to pay these costs and fees, if, for example, it finds his claim to be frivolous.