SUMMARY PLAN DESCRIPTION

OF THE

METAMORA HIGH SCHOOL

HEALTH BENEFIT PLAN

INTRODUCTION

The Metamora High School Health Benefit Plan ("Plan") is a self-funded health benefit plan established to provide hospital and medical benefits for employees of Metamora Township High School District No. 122 ("Employer"). This Plan represents the efforts of the Employer to provide its employees and their dependents with the best possible health benefits at an affordable cost.

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

In reviewing this booklet, you will note that a number of terms and phrases are capitalized. This usually means that there is a definition of these terms contained in the Definitions Section beginning on page 70. It will be helpful to refer to these definitions as you review your benefits.

If you would like to contact the Contract Administrator, you may do so between 9:00 A.M. and 5:00 P.M., Central Time, Monday through Friday, using the telephone numbers listed on the General Information page. However, any information that you obtain over the phone in this manner concerning your rights and benefits may not be relied upon as a guarantee of your rights or that benefits will be paid in that manner. The availability of benefits is determined solely on the basis of the terms of the Plan as contained in this booklet. A final determination of your rights and benefits cannot be made until all necessary documentation and information is submitted to the Contract Administrator and your claim is fully adjudicated.

METAMORA HIGH SCHOOL
HEALTH BENEFIT PLAN

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GENERAL INFORMATION

The following information, together with the information contained in this booklet, form the SUMMARY PLAN DESCRIPTION.

1. Name of Plan:

   Metamora High School Health Benefit Plan

2. Name and Address of Plan Sponsor and Plan Administrator:

   Metamora Township High School District No. 122
   101 W. Madison
   Metamora, IL 61548-0104
   (309) 367-4151

3. Employer Identification Number (EIN): 37-6005204

4. Plan Number: 501

5. Type of Plan:

   Welfare benefit plan providing medical benefits.

6. Funding

   The Plan is self-funded by Metamora Township High School District No. 122.

7. Contract Administrator:

   Consociate, Inc.
   2828 N. Monroe
   P.O. Box 1068
   Decatur, IL 62525-1068
   (217) 423-7788
   (800) 798-2422

8. Utilization Review Administrator

   Independent Third Party through the Contract Administrator
   Precertification Number: (800) 944-9401

9. Agent for Service of Legal Process:

David N. Schellenberg
Elias, Meginnes, Riffle & Seghetti, P.C.
416 Main, Suite 1400
Peoria, Illinois 61602
(309) 637-6000

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

10. Sources of Contributions to the Plan:

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

11. Fiscal Year of the Plan:

October 1 through September 30

12. Effective Date of the Plan:

October 1, 1998

13. Effective Date of Plan Restatement:

June 1, 2015

SUMMARY OF BENEFITS

Deductible and Out-of Pocket Levels

Deductible

Obtained from Preferred Provider

Per Individual $1,000*
Per Family $3,000*
(*Reduced in half if enrolled in wellness program administered by InterActive Health.)

Obtained from Non-Preferred Provider

Per Individual $2,000
Per Family $6,000

Preferred Provider and Non-Preferred Provider deductible amounts are calculated separately. The deductible applies unless otherwise stated.

Out-of-Pocket Maximum (including deductible and copayments)

Obtained from Preferred Provider

Per Individual $3,500
Per Family $10,500

Obtained from Non-Preferred Provider

Per Individual $7,000
Per Family $21,000

Preferred Provider and Non-Preferred Provider out-of-pocket amounts are calculated separately.

Major Medical Benefits

lnpatient Hospital Services

Obtained from Preferred Provider 80%
Obtained from Non-Preferred Provider 50%

Outpatient Surgery & Diagnostic

Obtained from Preferred Provider 80%
Obtained from Non-Preferred Provider 50%

Ambulatory Surgical Facility

Obtained from Preferred Provider 80%
Obtained from Non-Preferred Provider 50%

Emergency Treatment
Hospital Services ..... 80% after $350 copay, no deductible
Physician Services 80%

(Expenses apply to Preferred Provider deductible and out-of-pocket, if applicable)

Skilled Nursing Facility Confinement
Obtained from Preferred Provider 80%
Obtained from Non-Preferred Provider 50%

Second Surgical Opinions ..... 100%, no deductible

Physician's Services
Obtained from Preferred Provider 80%
Obtained from Non-Preferred Provider 50%
Office Visits obtained from Preferred Provider ..... 100%, after $30 copay for PCP and Urgent Care Providers, no deductible; $65 copay for specialist, no deductible

Mental & Nervous Disorders/Substance Abuse ..... same as any sickness

Preventative Care ..... 100%, no deductible

Outpatient Dialysis Treatment
Obtained from Preferred Provider ..... 100% after deductible
Obtained from Non-Preferred Provider ..... 100% after deductible

Prescription Drugs (Retail - 30-day supply)
Brand Name Drugs ..... $60 copay per prescription
Brand Name Drugs without Generic Substitute ..... $40 copay per prescription
Generic Drugs ..... $10 copay per prescription

Mail Order medications are available for 90 days and the copay is two times the copay for retail prescriptions.

If a Brand Name prescription is filled when a Generic is available, the appropriate copay plus the difference in cost will be charged.

All Other Covered Services
Obtained from Preferred Provider 80%
Obtained from Non-Preferred Provider 50%

MedCat Services for Cancer Care, Hemophilia, Human Organ & Tissue Transplant and Premature Babies

There are special assistance services available that can help obtain the best possible care for these conditions. In recognition of the positive impact these services can have on care, patients are covered at 100%, and their individual co-pay and deductible are waived when they participate in these programs.

Cancer patients newly or previously diagnosed and currently under treatment will be advised on treatment protocols that best match their condition for informed decision-making along with the assignment of a nurse care manager.

Hemophilia patients will be advised on how to switch to the preferred provider for their factor prescription fulfillment and will be assigned a nurse case manager.

Human Organ & Tissue Transplant patients will be advised of available network transplant providers and will be assigned a nurse case manager.

Premature baby patients' parent(s) will be contacted soon after the baby's birth to offer support and to work with the attending neonatologist during the baby's initial hospitalization.

To obtain these enhanced benefits, please contact the Contract Administrator.

DENTAL

Deductible

Preventive and Orthodontic Dental Services	$0
Basic and Major Dental Services	$50

Benefits

Preventive Dental Services	100%
Basic Dental Services	80%
Major Dental Services	50%
Orthodontic Dental Services	50%

Maximum Benefits

Preventive, Basic, and Major Dental Services	$1,000 per year
Orthodontic Dental Services	$1,000 per lifetime

Utilization Review

The Utilization Review Administrator must be notified prior to any scheduled or non-emergency admission to the Hospital or within forty-eight (48) hours after admission for Emergency Treatment or obstetric care. Failure to do so will result in a penalty in the form of a reduction in benefits otherwise computed. The reduction shall be the lesser of the (i) actual benefits available under the Plan, or (ii) $500. Call (800) 944-9401.

Maternity

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) hour (or ninety-six (96) hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours (or ninety-six (96) hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Women's Health and Cancer Rights Act

Federal law requires this Plan to provide the following benefits for elective breast reconstruction in connection with a mastectomy:

(1) reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and physical complications in all stages of mastectomy, including lymphedemas;

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

Caution

PLEASE READ BENEFIT BOOKLET CAREFULLY FOR A DETAILED EXPLANATION OF BENEFITS.

EMPLOYEE ELIGIBILITY

Eligibility Requirements

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

An Employee must enroll in the Plan within thirty-one (31) days of his initial Eligibility Date, during the Plan's open enrollment period in September of each year, or during an Employee Special Enrollment Period or Medicaid and CHIP Enrollment Period in order to obtain coverage under the Plan. An Employee is not eligible to enroll in the Plan at any other time.

Eligibility Date

A certified Employee shall be eligible for coverage on the first day of employment with the Employer and all other Employees shall be eligible for coverage immediately following thirty (30) days of employment with the Employer; provided he is properly enrolled in the Plan within thirty-one (31) days of that date. An Employee who applies for coverage during any open enrollment period established by the Employer shall be eligible for coverage on the date established by the Employer. An Employee who applies for coverage during an Employee Special Enrollment Period or Medicaid and CHIP Enrollment Period shall be eligible for coverage on the date of the event precipitating the Employee Special Enrollment Period or Medicaid and CHIP Enrollment Period.

Employee Special Enrollment Periods

An Employee who did not enroll in the Plan on his initial Eligibility Date may also enroll in the Plan during an Employee Special Enrollment Period. An "Employee Special Enrollment Period" shall be the thirty-one (31) day period immediately following one of the events described below:

(a) Loss of Other Coverage

The date the Employee exhausted coverage under a COBRA continuation provision of a group health plan, or the termination of coverage under another group health plan as a result of loss of eligibility for such coverage or the termination of employer contributions toward such coverage; provided the Employee was covered under a group health plan or had health insurance coverage at the time coverage under the Plan was previously offered to the Employee.

(b) Dependent Special Enrollment Period

(1) The date of Marriage of the Employee;

(2) The birth of a child of the Employee; or

(3) The adoption of a child by the Employee or the placement of a child in the home of the Employee while adoption proceedings are pending with respect to that child.

The Employee may only enroll for coverage during a Dependent Special Enrollment Period if the dependent described in subsections (1), (2), or (3) is also enrolled in the Plan during the thirty-one (31) day period described above.

Medicaid and CHIP Enrollment Periods

An Employee who did not enroll in the Plan on his initial Eligibility Date may also enroll in the Plan during a Medicaid and CHIP Enrollment Period. A "Medicaid and CHIP Enrollment Period" shall be the sixty (60) day period immediately following one of the events described below:

(a) The Employee is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the Employee under such plan is terminated as a result of loss of eligibility for such coverage; or

(b) The Employee becomes eligible for assistance, with respect to coverage under the Plan, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

DEPENDENT ELIGIBILITY

Eligibility for Dependent's Coverage

A Covered Person can obtain benefits for his Eligible Dependents under the Plan on:

(a) The date the Covered Person is eligible for coverage under the Plan, if on that date he has such Eligible Dependents; or

(b) The date the Covered Person gains an Eligible Dependent, if on that date he is covered by the Plan.

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

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

Eligibility Date of Dependent's Coverage

(a) The Eligibility Date of coverage for each Eligible Dependent will be the later of (i) the date on which the Covered Person who is the source of a dependent's eligibility becomes eligible for dependent coverage or (ii) the date the dependent becomes an Eligible Dependent, subject to the following:

(1) A newborn child of a Covered Person will be considered an Eligible Dependent from the moment of birth and will be eligible for benefits for Sickness or Injury, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled as a dependent of the Covered Person within thirty-one (31) days of the child's date of birth;

(2) A Spouse will be considered an Eligible Dependent from the date of Marriage, provided the Spouse is properly enrolled as a dependent of the Covered Person within thirty-one (31) days of the date of Marriage; and

(3) A dependent acquired other than at the time of birth due to court order, decree, Marriage, or placement in the home of the Covered Person while adoption proceedings are pending will be considered an Eligible Dependent from the date of such court order, decree, Marriage, or placement, provided that the dependent is properly enrolled as a dependent of the Covered Person within thirty-one (31) days of the date of the court order, decree, Marriage, or placement.

In situations where dependent coverage is already in effect prior to the date a dependent is acquired pursuant to paragraphs (1), (2) and (3) above, the thirty-one (31)-day period described above shall be deemed to be satisfied, provided that the Employee completes the proper enrollment forms within a reasonable time after acquiring the dependent. No claims will be processed under the Plan until the dependent is properly enrolled.

(b) An Eligible Dependent must enroll in the Plan within thirty-one (31) days of his initial Eligibility Date, during the Plan's open enrollment period in September of each year, or during a Special Enrollment Period or Medicaid and CHIP Enrollment Period in order to obtain coverage under the Plan. An Eligible Dependent is not eligible to enroll in the Plan at any other time.

An Eligible Dependent who applies for coverage during any open Enrollment Period established by the Employer shall be eligible for coverage on the date established by the Employer. An Eligible Dependent who applies for coverage during a Special Enrollment Period or Medicaid and CHIP Enrollment Period shall be eligible for coverage from the date of the event precipitating the Special Enrollment Period or Medicaid and CHIP Enrollment Period.

In no event will the Eligibility Date for a dependent precede the Eligibility Date for the Covered Person who determines the dependent's eligibility for benefits under the Plan.

Special Enrollment Periods

An Eligible Dependent may also enroll in the Plan during a Special Enrollment Period. A "Special Enrollment Period" shall be the thirty-one (31) day period immediately following one of the events described below:

(a) Loss of Other Coverage

The date the Eligible Dependent exhausted coverage under a COBRA continuation provision of a group health plan, or the termination of coverage under another group health plan as a result of loss of eligibility for such coverage or the termination of employer contributions toward such coverage; provided the Eligible Dependent was covered under a group health plan or had health insurance coverage at the time coverage under the Plan was previously offered to him.

(b) Dependent Special Enrollment Period

(1) The date of Marriage to the Employee;

(2) The birth of the Eligible Dependent; or

(3) The adoption of the Eligible Dependent by the Employee or the placement of the Eligible Dependent in the home of the Employee while adoption proceedings are pending with respect to that dependent.

An Eligible Dependent Spouse shall also be entitled to enroll for coverage along with the Eligible Dependent described in Subsections (2) and (3) above.

The Eligible Dependent may only enroll for coverage during a Special Enrollment Period if the Employee is also enrolled in the Plan on or before the thirty-one (31) day period described above.

Medicaid and CHIP Enrollment Periods

An Eligible Dependent who did not enroll in the Plan on his initial Eligibility Date may also enroll in the Plan during a Medicaid and CHIP Enrollment Period. A "Medicaid and CHIP Enrollment Period" shall be the sixty (60) day period immediately following one of the events described below:

(a) The Eligible Dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the Eligible Dependent under such plan is terminated as a result of loss of eligibility for such coverage; or

(b) The Eligible Dependent becomes eligible for assistance, with respect to coverage under the Plan, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

The Eligible Dependent may only enroll for coverage during a Medicaid and CHIP Enrollment Period if the Employee is also enrolled in the Plan on or before the sixty (60) day period described above.

BENEFITS

Limitations

(a) Shared Expenses

During each calendar year, except where specifically indicated to the contrary, each Covered Person or Covered Dependent shall be responsible for the deductible, copayment, and coinsurance requirements listed in the Schedule of Benefits. Expenses Incurred in October, November, and December which were applied to the deductible during the previous calendar year will also be applied to satisfy the deductible for the current calendar year. Expenses Incurred during the first nine (9) months of the previous calendar year will not be applied to satisfy the deductible during the current year.

(b) Maternity Benefits

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

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

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

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

(1) routine inpatient Hospital nursery charges; and

(2) one (1) routine inpatient examination by a Physician other than the Physician who delivered the child or administered anesthesia during delivery.

(c) Mental Illness

Benefits are only available for treatment of Mental Illness for services provided by or under the direction of a Physician or licensed clinical psychologist.

(d) Utilization Review Limitation

For treatment involving the provision of Hospital services, the Utilization Review Administrator must be notified with respect to any Covered Person or Covered Dependent (i) prior to any scheduled or non-emergency Hospital Confinement/Admission, or (ii) within forty-eight (48) hours after Hospital Confinement/Admission for Emergency Treatment or obstetric care.

Upon notification, the Utilization Review Administrator will review:

(1) the Medical Necessity for the Hospital Confinement/ Admission;

(2) the appropriateness of the place of treatment for the Sickness or Injury;

(3) the duration of the Hospital Confinement/Admission; and

(4) the extension, if necessary, of a previously certified Hospital Confinement/Admission.

If the Covered Person or Covered Dependent fails to notify the Utilization Review Administrator as required herein, or fails to follow the instructions of the Utilization Review Administrator following notification, the Hospital benefits otherwise available under the Plan, after application of all other limitations prescribed herein, shall be further reduced by the lesser of (i) actual benefits available, or (ii) $500.

Expenses excluded in accordance with this Section (d) shall not apply toward satisfaction of any other limitation in the Plan.

(e) Benefits Obtained from Preferred Provider

The Employer may enter into one or more Preferred Provider Agreements with certain health care service providers from time to time. Those participating providers are designated as Preferred Providers. As a result, covered services obtained from Preferred Providers are subject to a reduced Shared Expense limitation as described in the Summary of Benefits. A complete listing of all Preferred Providers is available free of charge from the Employer and is subject to change at any time.

Medical Benefits

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

Inpatient Hospital Services

(a) Hospital Services:

(1) regular Room and Board (semi-private room rate);

(2) confinement in an Intensive Care Unit; and

(3) Necessary Services and Supplies.

(b) Skilled Nursing Facility Confinement:

(1) Room and Board, including any charges made by the facility as a condition of occupancy or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, benefits available for Room and Board will not exceed the average semi-private rate charged by the facility or a representative cross section of similar institutions in the area;

(2) Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physician's fees; and

(3) Drugs, biologicals, solutions, dressings, and casts furnished for use during the convalescent period, but no other supplies.

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

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

(3) commences within thirty (30) days after a confinement in a Hospital for which benefits were payable under the Plan.

(c) Partial Hospitalization Treatment Program: Treatment in a planned therapeutic treatment program of a Hospital or Substance Abuse Treatment Facility in which patients with Mental Illness or Substance Abuse spend days or nights.

<u>Out-Patient Services</u>

(d) Out-Patient Treatment: Reasonable and Customary Expenses Incurred for the following Out-Patient Treatment:

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

(2) Diagnostic testing related to Surgery or medical care; and

(3) Services provided in an Ambulatory Surgical Facility.

(e) Emergency Room Treatment: Reasonable and Customary Expenses Incurred for initial Emergency Treatment of a Sickness or Injury in a Hospital emergency room or by a Physician.

(f) Pre-Admission Testing: Reasonable and Customary Expenses Incurred for pre-admission testing which is performed either:

(1) at a Hospital on an out-patient basis; or

(2) at an out-patient facility if the test results are accepted by the Hospital to which the patient is admitted;

provided that such testing is performed within seven (7) days prior to admission to that Hospital on an in-patient basis for treatment in connection with the Sickness or Injury to which the pre-admission testing relates. No benefits are available pursuant to this subsection if the treatment to which the testing relates is postponed, unless such postponement is Medically Necessary.

Physician Services

(g) Physician's services for surgical procedures, diagnostic services, Mental Illness, and Substance Abuse treatment.

(h) Office visits, house calls, or visits to a Hospital or facility by a Physician.

(i) Second surgical opinions and, if the second surgical opinion does not confirm the first opinion, a third opinion is also covered.

(j) Oral Surgery, as defined herein, including anesthesia and related charges.

(k) Anesthetics and their administration by a professional anesthetist or anesthesiologist.

(l) Dental Services rendered by a dentist or Physician which are required as a result of accidental Injury to the jaws, teeth, mouth or face.

(m) Special treatments, on an inpatient or outpatient basis, if rendered by a Physician or Hospital:

(1) X-ray and radiation therapy treatments;

(2) Chemotherapy;

(3) Shock therapy treatments;

(4) Renal dialysis treatments; and

(5) Allergy shots and allergy surveys.

Other Covered Services

(n) Routine Preventive Care, as defined herein.

(o) Routine pre-natal care.

(p) Private duty professional nursing services by a Registered Graduate Nurse or Licensed Practical Nurse, but only:

(1) on an inpatient basis, if the Employer determines that services provided are of such a nature or degree of complexity or quantity that they cannot be or are not usually provided by the regular nursing staff of the Hospital or other facility; or

(2) in the home, if the services provided are of such a nature that they cannot be provided by non-professional personnel.

(q) Local ground transportation provided by a professional ambulance service, to the nearest Hospital, between Hospitals, or between a Hospital and an Skilled Nursing Facility, including air ambulance service, when Medically Necessary.

(r) Processing and administration of blood or blood components, including the cost of the actual blood or blood components, unless replaced.

(s) Services for treatment of Mental Illness or Substance Abuse including treatment in a Substance Abuse Treatment Facility.

(t) The following medical supplies:

(1) prosthetic appliances required to replace all or part of an organ or tissue or the function of an organ or tissue, including adjustment, repair or replacement of such devices where required due to wear or a change in the patient's condition, but specifically excluding dental appliances or vision appliances other than cataract lenses or standard glasses required promptly after, and because of, cataract surgery;

(2) durable medical equipment, including such things as internal cardiac valves, internal pacemakers, paraffin baths, bone screws, bolts, nails, plates, wheelchairs, hospital beds, artificial limbs, and

other similar devices (rental or purchase, at the option of the Contract Administrator);

(3) dressings, sutures, casts, splints, trusses, crutches, braces or other necessary medical supplies with the exception of dental braces or corrective shoes;

(4) oxygen and rental equipment for its administration;

(5) leg, back, arm and neck braces required due to Sickness or Injury occurring subsequent to the Effective Date of coverage under the Plan (or its predecessor) of the Covered Person or Covered Dependent;

(6) prescription legend drugs obtained through the drug card program described in Addendum A; and

(7) prescription legend drugs not obtained through the drug card program.

(u) Chiropractic services performed by a chiropractor or Physician, limited to $1,000 per calendar year.

(v) Services for voluntary sterilization for Covered Persons or their Spouses.

(w) Services which are legally rendered by an optometrist, provided that benefits would have been provided had such services been rendered by a Physician.

(x) Services of a Physician or licensed physical therapist for physical therapy. Benefits for physical therapy (other than for Habilitative Services) are limited to thirty (30) visits per Sickness or Injury unless Medically Necessary and approved in advance by the Contract Administrator;

(y) Services of a qualified Physician or qualified speech therapist for restoratory or rehabilatory speech therapy for speech loss or impairment due to Sickness or Injury, or due to a congenital anomaly. Benefits for speech therapy (other than for Habilitative Services) are limited to thirty (30) visits per Sickness or Injury unless Medically Necessary and approved in advance by the Contract Administrator;

(z) Services of a Physician or registered occupational therapist for constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Benefits for occupational therapy (other than for Habilitative Services) are limited to thirty (30) visits per

Sickness or Injury unless Medically Necessary and approved in advance by the Contract Administrator;

(aa) Cardiac rehabilitation services provided within six (6) months following a Hospital Admission for either myocardial infarction, coronary artery bypass Surgery, percutaneous transluminal coronary angioplasty, or other open heart Surgery. Benefits are limited to thirty-six (36) outpatient treatment sessions.

(bb) Routine patient costs related to an approved clinical trial as required by 42 USC 300gg-8.

(cc) Routine pap smears.

(dd) Routine digital rectal examinations and prostate-specific antigen tests.

(ee) Colorectal cancer screening.

(ff) Surveillance tests for ovarian cancer.

(gg) Osteoporosis bone mass measurement and the diagnosis and treatment of osteoporosis.

(hh) Routine clinical breast examinations performed by a Physician, physician assistant, or Registered Nurse.

(ii) Human papillomarivus vaccines approved by the federal Food and Drug Administration.

(jj) Amino acid-based elemental formulas, regardless of delivery method, for the diagnosis and treatment of (i) eosinophilic disorders and (ii) short bowel syndrome.

(kk) Vaccine for shingles that is approved for marketing by the Federal Food and Drug Administration when ordered by a Physician for Covered Persons or Covered Dependents age sixty (60) and over.

(ll) Habilitative Services for Covered Dependents under age nineteen (19) for treatment of congenital, genetic, and early acquired disorders including but not limited to autism or autism spectrum disorder, cerebral palsy, and other disorders resulting from early childhood Sickness, Injury, or trauma.

(mm) Diagnosis and treatment of autism spectrum disorders for Covered Dependents under age twenty-one (21).

(nn) A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue when medically necessary as determined by a Physician.

(oo) Out-Patient Self-Management Training and Education, equipment, supplies, and foot care for the treatment of Type I diabetes, Type II diabetes, and gestational diabetes mellitus as follows:

(1) Covered medical supplies:

(A) blood glucose monitors;

(B) blood glucose monitors for the legally blind;

(C) cartridges for the legally blind; and

(D) lancets and lancing devices.

(2) Covered pharmaceuticals and supplies:

(A) insulin;

(B) syringes and needles;

(C) test strips for glucose monitors;

(D) FDA approved oral agents used to control blood sugar; and

(E) glucagon emergency kits.

Notwithstanding the foregoing, any item listed herein that is an eligible expense under any separate prescription drug card benefit maintained by the Employer shall not be considered an eligible expense under this Plan.

(3) Regular foot care exams by a Physician.

Benefits for Outpatient Self-Management Training and Education are limited as follows:

(1) Three (3) visits to a Physician or certified, registered, or licensed health care professional with expertise in diabetes management during the first year following the initial diagnosis of diabetes; and

(2) Two (2) visits to a certified, registered, or licensed health care professional within one (1) year following a significant change in the patient's symptoms or condition. A "significant change" in the patient's condition means symptomatic hyperglycemia (greater than 250 ml/dl on repeated occasions), severe hypoglycemia (requiring the assistance of another person), onset or progression of diabetes, or a significant change in medical condition that would require a significantly different treatment regimen.

(pp) The following benefits for elective breast reconstruction in connection with a mastectomy:

(1) reconstruction of the breast on which the mastectomy has been performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and physical complications in all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient.

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

(1) Benefits

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

Expenses covered under this Section include:

(A) part-time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse; or

(B) physical therapy, occupational therapy, respiratory therapy and speech therapy provided by the Home Health Care Agency; or

(C) medical supplies, drugs and medications prescribed by a Physician, and laboratory services by or on behalf of a Hospital, to the extent such items would have been paid by

the Plan if the Covered Person or Covered Dependent had remained in the Hospital.

(2) Limitations

No benefits are payable under this Section for:

(A) services or supplies not covered by the Home Health Care Plan;

(B) Services performed by an individual who ordinarily resides in the Covered Person's or Covered Dependent's home or is a member of the Covered Person's or Covered Dependent's Immediate Family;

(C) Services of any social worker;

(D) Expenses Incurred for transportation;

(E) Services or supplies rendered during any period in which the Covered Person or Covered Dependent is not under the continuing care of a Physician.

(rr) Transplant Benefits

(1) Human Organ Transplants

Reasonable and Customary Expenses Incurred for the following named human organ transplants: cornea, kidney, bone marrow, heart valve, muscular-skeletal, heart, lung, heart/lung, liver, pancreas, or pancreas/kidney human organ or tissue transplants, subject to the following:

(A) If both the donor and recipient are covered by the Plan, each shall have their benefits computed in accordance with the provisions of their own coverage;

(B) If the recipient is covered by the Plan and the donor has no other source of benefits, benefits for both the donor and the recipient shall be computed in accordance with the provisions governing the recipient's eligibility for benefits under the Plan; and

(C) lf the donor is covered by the Plan and no benefits are available to the donor from any other source, benefits shall

be provided to the donor under the provisions of the Plan, but no benefits shall be provided to the recipient.

(2) Additional Human Organ Transplants

Reasonable and Customary Expenses Incurred for the following named human organ transplants: heart, heart/lung, liver, pancreas, or pancreas/kidney, subject to the following:

(A) Benefits are available pursuant to this Subsection (2) for Expenses Incurred within five (5) days prior to and three hundred sixty-five (365) days following the transplant Surgery, for all inpatient and outpatient services related to the transplant Surgery;

(B) Benefits are available for transportation of the donor organ to the location of the transplant Surgery, limited to transportation in the United States or Canada; and

(C) Benefits for transplants pursuant to this Subsection (b) are available only at Hospitals which have transplant programs approved by the Employer or Contract Administrator.

In addition to other limitations provided herein, benefits available pursuant to this Subsection (2) do not include the following:

(A) Services unrelated to the transplant or to the diagnosis or treatment of a Sickness resulting directly from such transplant;

(B) Cardiac rehabilitation services when not provided to the transplant recipient immediately after discharge from the Hospital Confinement/Admission for transplant surgery;

(C) Transportation by air ambulance for the donor or the recipient;

(D) Travel time and related expenses required by a Physician; or

(E) Experimental drugs.

<u>Dialysis Treatment - Outpatient</u>

This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Covered Persons and Covered

Dependents and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

(a) Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:

(1) the concentration of dialysis providers in the market in which Covered Persons and Covered Dependents reside may allow such providers to exercise control over prices for dialysis-related products and services,

(2) the potential for discrimination by dialysis providers against the Plan because it is a non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Covered Persons and Covered Dependents,

(3) evidence of (i) significant inflation of the prices charged to Covered Persons and Covered Dependents by dialysis providers, (ii) the use of revenues from claims paid on behalf of Covered Persons and Covered Dependents to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-commercial plans by the dialysis providers as profit centers, and

(4) the desire to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Covered Persons and Covered Dependents, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Covered Persons' and Covered Dependents' interests, such as subsidies for other plans and discriminatory profit-taking.

(b) Dialysis Program Components. The components of the Dialysis Program are as follows:

(1) Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Covered Persons and Covered Dependents for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis (“dialysis-related claims”).

(2) Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after October 1, 2013, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Covered Person or Covered Dependent.

(3) Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator shall consider factors including:

(A) Market concentration: The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

(B) Discrimination in charges: The Plan Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

(4) In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Covered Person or Covered Dependent, to the following payment limitations, under the following conditions:

(A) Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Covered Person or Covered Dependent, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

(B) Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Covered Persons or Covered Dependents, upon the

Plan Administrator's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.

(C) Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

(D) Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

(E) Additional Information related to Value of Dialysis-Related Services and Supplies. The Covered Person or Covered Dependent, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

(F) All charges must be billed by a provider in accordance with generally accepted industry standards.

(5) Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Covered Person or Covered Dependent is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or

services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

(6) Discretion. The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law.

Dental Benefits

(a) Services

Reasonable and Customary Dental Expenses Incurred for:

(1) Preventative Dental Services;

(A) routine oral examinations, up to a maximum of one (1) examination every six (6) months;

(B) prophylaxis (cleaning, scaling and polishing), up to a maximum of one (1) treatment every six (6) months;

(C) topical fluoride application, limited to persons under age fourteen (14), but not more than one (1) application every six (6) months;

(D) Emergency Treatment;

(E) space maintainers, limited to persons under age sixteen (16) and limited to initial appliance only.

(F) topical application of sealant to posterior teeth, limited to the unrestored permanent molar teeth of persons under age sixteen (16) and limited to one application every thirty-six (36) months;

(G) dental x-rays as follows: full mouth x-rays only payable once every sixty (60) month period and additional bite wing x-rays are payable one each twelve (12) month period;

(H) other intraoral periapical or occlusal films, limited to four (4) periapical and two (2) occlusal films every twelve (12) months;

(I) extraoral superior or inferior maxillary films, limited to two (2) every twelve (12) months; and

(J) panoramic film, maxilla and mandible (only for treatment of accidents, cysts and tumors).

(2) Basic Dental Services

(A) fillings;

(B) biopsies of oral tissue;

(C) general anesthesia, if administered in conjunction with performance of another covered dental procedure; and

(D) Consultations with a dentist other than the one providing treatment, limited to one (1) visit every twelve (12) months.

(3) Major Dental Services

(A) extractions;

(B) pulp vitality tests, limited to one (1) test per calendar year;

(C) apicoectomies;

(D) hemisection;

(E) repair of removable dentures;

(F) recementing of crowns, inlays and bridges;

(G) endodontics;

(H) periodontics, including gingivectomy and gingivoplasty, gingival curettage, osseous surgery, surgical periodontic examination, mucogingivoplastic surgery and management of acute periodontal infection and oral lesions;

(I) inlays, onlays and crowns (except for temporary crowns);

(J) bridges and bridge repairs;

(K) full and partial dentures; and

(L) denture adjustments and relining during first six (6) months after obtaining dentures or having them repaired, provided that the services are performed by someone other than the

dentist or his associates who provided or repaired the dentures.

Replacements of crowns, bridges or dentures are not covered (1) until ten (10) years have elapsed since the original acquisition of the crowns, bridges or dentures, or unless additional teeth have been extracted, and (2) unless the original crowns, bridges or dentures could not have been repaired and made serviceable.

(4) Orthodontic Services

(Only for Covered Dependents who are less than nineteen (19) years old when the active appliance is first placed.)

(A) Any Preventive, Primary, or Major Dental Services connected with orthodontic treatment;

(B) surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment, including routine x-rays, local anesthetics, and post-surgical care; and

(C) active appliances of all types, including diagnostic services, the treatment plan, the fitting, making and replacing of the active appliance, and all related office visits including post-treatment stabilization.

(b) Limitations

(1) Deductible Expenses

During each calendar year, except where specifically indicated to the contrary, each Covered Person or Covered Dependent shall be responsible for the first $50 of covered Expenses Incurred ("Deductible Expenses") pursuant to this Dental Benefits Section. This limitation does not apply to Expenses Incurred for Preventive or Orthodontic Dental Services as defined herein.

If a Covered Person or Covered Dependent incurs Deductible Expenses during the last three (3) months of a calendar year, such expenses shall also be considered Deductible Expenses for the next calendar year as well.

Notwithstanding any provision in this Section to the contrary, the total number of Deductible Expense limits to be paid by a Covered Person and his Covered Dependents during one (1) calendar year under the provisions of this Section shall not exceed three (3).

The Deductible Expenses incurred under this Section of the Plan shall not be applied to satisfy the Deductible Expense requirement under any other Section of the Plan.

(2) Shared Expenses

Notwithstanding any provision herein to the contrary, during each calendar year, a Covered Person or Covered Dependent shall be responsible for a portion of Reasonable and Customary Expenses Incurred pursuant to this Dental Benefits Section, in excess of the expenses excluded pursuant to Subsection (1) above, determined in accordance with the following schedule:

Benefits	Coinsurance
Preventive	0%
Basic	20%
Major	50%
Orthodontic	50%

(3) Maximum Dental Benefits

Notwithstanding any provision herein to the contrary, the maximum benefits available for each Covered Person or Covered Dependent for Preventive, Basic and Major Dental Services shall not exceed $1,000 per calendar year for all benefits. The maximum lifetime benefits for Orthodontic Dental Benefits is $1,000.

(4) Precertification

If a dentist recommends a course of treatment with an estimated cost of more than $200, the dentist must prepare a report describing the planned treatment, including copies of necessary x-rays, photographs and models and an estimate of the total cost of the course of treatment. A treatment report must be prepared for all planned orthodontic treatment regardless of the estimated cost. The Contract Administrator will review the proposed course of treatment and will notify the Covered Person or Covered Dependent and dentist of the benefits available under the Plan.

(5) Alternate Benefits

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

(6) Care By More Than One (1) Dentist

If a Covered Person or Covered Dependent switches dentists during a particular course of treatment, benefits will be provided as if the course of

treatment had been provided under the original treatment plan.

(7) Limitations

The following limitations apply to benefits provided pursuant to this Dental Benefits Section, in addition to those limitations specified in the General Limitations Section which are applicable to all benefits provided under the Plan. Pursuant to these additional limitations, no benefits will be provided under this Section for:

(A) dental services not ordered by a Dentist or Physician;

(B) dental services which do not meet the standards set by the American Dental Association;

(C) dental services incurred due to loss or theft of dentures or bridges;

(D) dental services obtained for cosmetic reasons, including altering or extracting and replacing sound teeth to change appearance;

(E) the following items:

(i) myofunctional therapy;

(ii) athletic mouthguards;

(iii) implants or tooth transplants;

(iv) oral hygiene, dietary, plaque control and other educational programs;

(v) duplicate prosthetic appliances;

(vi) 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;

(vii) precision attachments;

(viii) desensitizing medicaments;

(ix) splinting or stabilizing teeth for periodontic reasons; or

(x) replacement of tooth structure resulting from abrasion or attrition.

(c) Extension of Benefits

No charges will be paid for Expenses Incurred after the date coverage under the Plan terminates, except that the following will be paid for work completed within thirty-one (31) days of termination:

(1) a crown, bridge, or cast restoration, if the tooth is prepared before coverage terminates;

(2) any other prosthetic device, if the master impression is made before coverage terminated; or

(3) root canal treatment, if the pulp chamber is opened before coverage terminates.

GENERAL LIMITATIONS

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

(a) for charges which exceed the Reasonable and Customary charge for the service rendered or charges for which payment is not legally required;

(b) for treatment paid for by any agency of the United States Government or any state or political subdivision, or provided by or in a Hospital operated by any agency of the United States Government or any state or political subdivision, unless Covered Person or Covered Dependent is legally required to pay such charges;

(c) for or in connection with:

(1) Sickness or Injury for which the Covered Person or Covered Dependent is entitled to benefits under any Worker's Compensation Law, Employer's Liability Law, or similar laws;

(2) Hospital, surgical, and medical services or supplies unless such expense is incurred upon the recommendation of a Physician for diagnosis or treatment of an Injury or Sickness;

(3) Injury or Sickness arising out of war, declared or undeclared, or service in any military forces or civilian non-combatant unit serving with such forces;

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

(5) cosmetic surgery, except for

(A) treatment necessitated by accidental Injury sustained while the individual was covered under the Plan or for correction of a congenital malformation of a dependent child,

(B) reconstructive breast surgery resulting from a Sickness or Injury occurring while the Covered Person or Covered Dependent is covered under the Plan;

(6) services performed by any person who is a member of the Covered Person's or Covered Dependent's Immediate Family, or who normally resides in the Covered Person's or Covered Dependent's home;

(7) except as specified elsewhere, health examinations of a routine periodic nature or Expenses Incurred for immunizations not necessary for treatment of a Sickness or Injury;

(8) services, supplies or treatments not Medically Necessary for the diagnosis and/or treatment of an active Sickness of Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value; or drugs not approved for use by the U. S. Food and Drug Administration;

(9) charges incurred outside the United States if the Covered Person or Covered Dependent traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies;

(10) hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations or tests not connected with the actual Sickness or Injury, except as otherwise specified herein;

(11) the purchase or fitting of eyeglasses, contact lenses, hearing aids, or such similar aid devices. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery;

(12) replacement of cataract lenses when a prescription change is not required;

(13) professional nursing services if rendered by other than a Registered Graduate Nurse or Licensed Practical Nurse, unless such care was vital as a safeguard of the Covered Person's or Covered Dependent's life, and unless such care is specifically listed as a benefit elsewhere in the Plan;

(14) treatment or Surgery for obesity, except for endogenous morbid obesity;

(15) lQ testing or educational training;

(16) maintenance occupational therapy, maintenance physical therapy, or maintenance speech therapy;

(17) 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;

(18) vitamins or dietary supplements;

(19) housekeeping or custodial care;

(20) weak, unstable or flat feet, or bunions, unless an open cutting operation is performed or for treatment of corns, calluses or toenails, unless at least part of the nail root is removed, or purchase of orthopedic shoes or other devices for support of the feet except as prescribed by a Physician;

(21) treatment of temporomandibular joint syndrome with intraoral prosthetic devices, or any other procedure to alter vertical dimension;

(22) enrollment in a health, athletic, or similar club or weight loss, nonsmoking or similar programs, except as otherwise specifically provided herein;

(23) purchase or rental of supplies of common use such as: exercise cycles, air purifiers, air conditioners, water purifiers, hypoallergenic pillows or mattress or waterbeds;

(24) purchase or rental of: motorized transportation equipment, escalators, or elevators, saunas, steambaths, swimming pools, or blood pressure kits;

(25) sex transformation and hormones related to such treatment;

(26) radial keratotomy or keratoplasty;

(27) chelation therapy;

(28) elective abortions, except where necessary to preserve the life of the mother;

(29) Expenses Incurred for special education or training for learning disabilities; or

(30) Expenses incurred for acupuncture;

(31) services and supplies not specifically mentioned in the Plan.

(d) Expenses for "experimental treatment" for a Covered Person or Covered Dependent. For the purpose of this section, a treatment or procedure shall be deemed an "experimental treatment" when the treatment or procedure involved is given that designation or a similar designation in connection with the administration of Medicare or by the American Medical Association. In addition, a transplant procedure shall be deemed an "experimental treatment" if it is not one of the procedures specified in the section on Transplant Benefits.

CLAIM PROVISIONS

The payment of any benefit set forth in this Plan is subject to the provision that the Covered Person or Covered Dependent furnish such proof of loss that the Plan Administrator may reasonably require before approving the payment of such benefit.

Proof of loss must be furnished to the Contract Administrator, not later than ninety (90) days after the loss. Claims that are not submitted to the Contract 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:

(a) Obtain a claim form from the Employer. Complete the claim form, making sure that it includes the Covered Person's employee identification number (as shown on the ID card) and group number (as shown on the ID card).

(b) 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.

(c) If the Covered Person or Covered Dependent is covered under another group insurance plan that is primary, the claim must be filed under the primary plan first. The Covered Person or Covered Dependent 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.

(d) After completing the claim form, mail it to the address stated in the General Information section.

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.

Following is a description of how the Plan processes claims for benefits. A claim is defined as a rescission of coverage or 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 or Covered Dependent'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 treatment or not Medically Necessary or appropriate, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the claim. Please contact the Contract Administrator with any questions.

The definitions of the types of claims are:

Urgent Care Claim

A claim involving Urgent Care is any claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or

in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

A Physician with knowledge of the claimant's medical condition may determine if a claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
Insufficient information on the claim, or failure to follow the Plan's procedure for filing a claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an adverse benefit determination on a claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be

transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim

A Pre-Service claim means any claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

In the case of a Pre-Service claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a claim	5 days
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	15 days per benefit appeal
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

Post-Service Claim

A Post-Service claim means any claim for a Plan benefit that is not an Urgent Care claim or a Pre-Service claim; in other words, a claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the claim	15 days
Response by claimant following notice of insufficient information	45 days
Review of adverse benefit determination	30 days per benefit appeal

Notice to Claimant of Adverse Benefit Determinations

Except with Urgent Care claims, when the notification may be oral followed by written or electronic notification within three (3) days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the determination was based.

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

(d) A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures.

(e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

(f) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

(g) If the adverse benefit determination is based on the Medical Necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeals

When a claimant receives an adverse benefit determination, the claimant has one hundred eighty (180) days following receipt of the notification in which to appeal the decision to the Contract Administrator for consideration by the Plan Administrator. A claimant may submit written comments, documents, records, and other information relating to the claim, and if desired may present evidence and testimony regarding the claim to the Plan Administrator. If the claimant so requests, he or she may review the claim file and will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The Plan will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim as soon as possible and sufficiently in advance of the date the appeal must be decided. Before the Plan can issue a final adverse benefit determination based on a new or additional rationale, the claimant will be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date the appeal must be decided to give the claimant a reasonable opportunity to respond prior to that date.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

(a) was relied upon in making the benefit determination;

(b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination nor the subordinate of any such professional. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be appropriately identified to the claimant.

The Plan will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, personnel decisions, or other similar decisions, will not be based upon the likelihood that an individual will support the denial of benefits.

The Plan will further ensure that:

(a) Any notice of adverse benefit determination or decision on appeal include information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable), and a statement describing the availability as soon as practicable, upon request, of the diagnosis code, and the treatment code and their

corresponding meanings. A request for this information will not, in itself, be considered an appeal.

(b) In the case of a decision on appeal, the decision shall include a discussion of the decision.

(c) The Plan will proivde a description of available internal appeals and external review processes, including how to initiate an appeal and the availability of and contact information for any assistance or or ombudsman to assist individuals with internal claims and appeals and external review processes.

External Appeals

When a claimant receives an adverse benefit determination on appeal of a claim that involves medical judgment or a recission of coverage, the claimant has four (4) months after the date of receipt of a notice of the notice of denial of the appeal in which to file a request for an external review of the adverse benefit determination. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth (5th) month following the receipt of the notice. Claims involving "medical judgment" for this purpose include, but are not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or the Plan's determination that a treatment is experimental. A claim that does not involve a medical judgment or recission is not eligible for an external review and the Plan's decision on appeal is final.

Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

(a) The claimant is or was covered under the Plan at the time the claim was incurred;

(b) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process applicable law; and

(d) The claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notification must describe the information or materials needed to make the request complete and the Plan must allow the claimant to perfect the request for external review within the four (4)-month filing period or within the forty-eight (48) hour period following the receipt of the notification, whichever is later.

The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. The Plan will take action against bias and to ensure independence. The Plan will contract with at least three (3) IROs for assignments under the Plan and rotate claims assignments among them. In addition, the IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between the Plan and an IRO must provide the following:

(a) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

(b) The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within ten (10) business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

(c) Within five (5) business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

(d) Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan will not

delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one (1) business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Plan.

(e) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

(5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(6) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(f) The assigned IRO must provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for

the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.

(g) The assigned IRO's decision notice will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;

(6) A statement that judicial review may be available to the claimant; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(h) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six (6) years. An IRO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Appeals

The Plan shall allow a claimant to request an expedited external review of an adverse benefit determination if:

(a) The adverse benefit determination involves an urgent care claim of the claimant for which the timeframe for completion of an expedited internal appeal under the external review procedures would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

(b) If the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the receipt of the request for expedited external review, the Plan will complete the preliminary review of the request as for a standard external review and immediately notify the claimant of the claimant's right to an expedited review.

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements applicable to a standard external review above. The Plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers the appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusion reached during the Plan's internal claims and appeals process.

The Plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decisions, in accordance with the requirements applicable to a standard external review above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

Authorized Representatives

A Covered Person or Covered Dependent may pursue a benefit claim or appeal an adverse benefit determination on his own behalf or through an authorized representative. An authorized representative may be (i) a health care professional with knowledge of the claimant's medical condition, (ii) an attorney at law representing the claimant, (iii) a Spouse or relative of the claimant, or (iv) any other individual authorized to act on behalf of the claimant. The authorized representative shall provide evidence, sufficient to the Employer or Contract Administrator, that the representative is duly authorized by the claimant to act on his behalf. A written instrument signed by the claimant or, in the case of a minor, the Employee appointing an authorized representative shall be sufficient authorization until revoked.

Facility of Payment

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

Minor or Incompetency

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

Discharge

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

Legal Actions

All claims review procedures provided for by the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

Time Limitations

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

Claims Mistakenly Paid

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

ADMINISTRATION

Assignment Not Permitted

Notwithstanding anything in the Plan to the contrary, except for the assignment to a service provider of the right to receive direct payment from the Plan for covered charges properly payable under the Plan for services or supplies rendered by the service provider, no assignment of the Plan or any rights or benefits thereunder by a Covered Person or Covered Dependent shall be allowed, recognized, or effective against the Plan. The Plan Administrator may refuse to accept an assignment to a provider of the right to receive direct payment from the Plan if the Plan Administrator believes, in its discretion, that doing so would be helpful or advantageous to the Covered Person or Covered Dependent, to the efficient administration of the Plan, or for litigation purposes.

Individual Benefits Management

In addition to the benefits otherwise described in the Plan, if a medical condition would otherwise require continued long-term care in a Hospital or other health care facility, the Employer may offer alternative benefits for services rendered in accordance with an alternate treatment plan which is approved by the Covered Person or Covered Dependent, the attending Physician, and the Employer.

Alternative benefits will be provided only so long as the Employer determines that the alternative services are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which the Covered Person or Covered Dependent would otherwise be entitled under the regular provisions of the Plan in the absence of the alternative benefits.

A Covered Person or Covered Dependent may send a written request to the Contract Administrator to be considered for alternative benefits. However, the Employer will make the final determination of eligibility to receive alternative benefits.

The Employer's election to provide alternative benefits in one instance shall not obligate it to provide alternative benefits in any other instance. In addition, the Employer's offering or providing alternative benefits shall not be construed as a waiver of any of the terms, provisions, or limitations of the Plan.

Withholding of Benefit Payments

In the event any question or dispute shall arise as to the proper person or persons to whom any payments shall be made hereunder, the Employer may direct the Contract Administrator to withhold such payment until there shall have been made an adjudication of such question or dispute which in the Employer's sole judgment is satisfactory to it, or until the Employer and Contract Administrator shall have been fully protected against loss by means of such indemnification agreement or bond as it determines to be adequate.

Medical Examination

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

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

Right to Receive and Release Information

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

The only employees or other persons under the direct control of the Plan Sponsor who are allowed access to the protected health information of other individuals are those employees or persons with direct responsibility for the control and operation of the Plan and only to the extent necessary to perform the duties as Plan Administrator

as determined pursuant to the reasonable exercise of discretion of the Plan Administrator.

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

(a) Not use or further disclose the information other than as permitted or required by the Plan or as required by law;

(b) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(c) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(d) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(e) Report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make available protected health information in accordance with 45 C.F.R. 164.524;

(g) Make health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526;

(h) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;

(i) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, *et seq.*;

(j) If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make

the return or destruction of the information infeasible; and

(k) Ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

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

Facility of Reimbursement

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

Right to Recovery

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

No benefits shall be paid (whether reduced or not) under this provision, to the extent that it would be inconsistent with any definition, limitation, condition, exception or other policy provision applying to this Plan.

Subrogation

In the event any benefits or services of any kind are furnished to a Covered Person or Covered Dependent, or payment made or credit extended to or on behalf of any Covered Person or Covered Dependent for a physical condition or Injury caused by a third party or for which a third party may be liable, the Plan shall be subrogated and shall succeed to individual rights of recovery against any such third party to the full extent of the value of any such benefits or services furnished or payments made or credit extended without reduction for the Covered Person or Covered Dependent's attorney's fees, or application of the common fund doctrine, make whole doctrine, Rimes doctrine, or any other similar legal theory. The Covered Person or Covered Dependent shall immediately upon recovery of any funds or other property agree to

reimburse the Plan out of the proceeds of any recovery no less than one hundred percent (100%) of the benefits provided under the Plan, as described above. The Covered Person or Covered Dependent agrees to pay all of his own legal fees incurred in litigation against such third parties, and to hold the Plan harmless against any claims made against the Plan by the attorneys retained by the Covered Person or Covered Dependent.

The Covered Person or Covered Dependent shall, at the Plan's request, take such action, furnish such information and assistance, and execute such documents as the Plan may require to facilitate enforcement of its rights hereunder. In the event that the Plan would have a subrogation interest upon payment of benefits, the Plan may prior to such payment require the Covered Person or Covered Dependent in writing to:

(a) reimburse the Plan one hundred percent (100%) of the benefits actually provided without reduction for, or application of, the common fund doctrine, make whole doctrine, Rimes doctrine, or any other similar legal theory, immediately upon collection of damages by him, whether obtained by action at law, settlement, or otherwise; and

(b) provide the Plan with a first lien to the extent of benefits provided by the Plan. Said lien may be filed with any person or organization liable, or potentially liable, to the Covered Person or Covered Dependent for indemnification, the Covered Person or Covered Dependent's attorney, or the court.

In the event of the Covered Person's or Covered Dependent's failure to comply with any such request made prior to or after payment of benefits, the Plan shall be entitled to withhold benefits, services, payments or credits due under the Plan, or to initiate or maintain any legal proceedings it deems necessary to protect the rights of the Plan, as provided herein. The Covered Person or Covered Dependent shall do nothing prior to or following acceptance of benefits hereunder to prejudice the subrogation rights, or potential subrogation rights, of the Plan.

In the event the Covered Person or Covered Dependent or his personal representative fails to institute a proceeding against such third person at any time prior to three (3) months before such action would be barred, the Plan may in its own name or in the name of the Covered Person or Covered Dependent or their personal representative commence a proceeding against such other third person for the recovery of all damages in the full extent of the value of any such benefits or services furnished or payments made or credit extended by the Plan. Out of any amount recovered, the Plan shall pay over to the Covered Person or Covered Dependent or their personal representative all sums collected from such third person by judgment or otherwise in excess of the amount of such services, payments, or credit extended or paid by the Plan on behalf of the Covered Person or Covered Dependent and costs, attorneys' fees and reasonable expenses as may be incurred by the Plan in making such in collection or enforcing such liability.

Excess Insurance Provision

If at the time of Injury or Sickness there is available, or is potentially available based on information known or provided to the Plan Administrator or Contract Administrator, to the Covered Person or Covered Dependent any other insurance, or other form of indemnification, including but not limited to judgment at law or settlements, the benefits under this Plan shall apply only as excess insurance over such other sources of indemnification; by way of illustrating but not in limitation, this provision shall be applicable to those Expenses Incurred as the result of Sickness or Injury when:

(a) the Covered Person or Covered Dependent is injured by or in the course of operating a motor vehicle;

(b) the Covered Person or Covered Dependent is injured on the premises insured by the owner occupier for indemnification;

(c) the Covered Person or Covered Dependent is injured by a third-party tort feasor; or

(d) the Covered Person or Covered Dependent is injured while maintaining the status of a full-time student.

If, in the discretion of the Employer, payment of medical expenses is made when the provisions of this Section apply, or at a time when such provisions may later become applicable, said payment may be made on the condition that the Covered Person or Covered Dependent agrees in writing to:

(1) reimburse the Plan one hundred percent (100%) of the benefits actually provided without reduction for, or application of, the common fund doctrine, make whole doctrine, Rimes doctrine, or any other similar legal theory, immediately upon collection of damages by him, whether obtained by action at law, settlement, or otherwise; and

(2) provide the Plan with a first lien to the extent of benefits provided by the Plan. Said lien may be filed with any person or organization liable, or potentially liable, to the Covered Person or Covered Dependent for indemnification, the Covered Person or Covered Dependent's attorney, or the court.

Coordination of Benefits

In addition to benefits payable under this Plan, a Covered Person or Covered Dependent may be entitled to benefits from other plans, payable on account of the same Sickness or Injury. The other plans are those which provide benefits or services

for or by reason of medical or dental care or treatment, when such benefits or services are provided on a group basis, whether insured or not, by any government or tax-supported program (including Medicare) or any similar plan or program.

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

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

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

(a) If one plan has no coordination of benefits provision, it is automatically Primary.

(b) A plan will be Primary if it covers the individual as an Employee and Secondary if it covers the individual as a Dependent.

(c) If an individual is covered as a Dependent under two or more plans, the plan which covers the individual as a Dependent of the person whose birthday falls earlier in the year is Primary. If both individuals share the same date of birth, the plan covering the individual for the longer period of time is Primary.

(d) In the case of children of divorced parents, in the absence of court-determined responsibility, the plan covering the parent with custody is Primary. If the parent without custody has court-determined responsibility, but does not have health benefits available for children, then the plan covering the parent with custody is Primary.

(e) A plan will be Primary if it covers the individual as an Employee and Secondary if it covers the individual (i) as a former Employee, (ii) as a retiree, or (iii) as an individual who has elected to continue benefits under the Plan pursuant to the Continuation of Benefits Sections herein.

(f) If none of the above rules apply, a plan will be Primary if it has covered the individual for the longer period of time and Secondary if it has covered the individual for the shorter period of time.

Notwithstanding any provision herein to the contrary, if a Covered Person or Covered Dependent is eligible for Medicare, benefits otherwise payable on behalf of

that Covered Person or Covered Dependent shall be reduced by the amount of benefits available from Medicare, regardless of whether such benefits are actually received from Medicare.

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

Dissimilar Plans

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

(a) For the person for whom the Plan coordinates benefits (a Dependent under this Plan), there are one or more plans (other than this Plan) from which to choose to be his/her 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 provided the most benefits that are available);

(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 the secondary plan to provide benefits for Expenses Incurred but for which benefits were not paid by the primary plan is limited. This Plan, the secondary plan, will coordinate coverage as the secondary plan using its own benefit plan as the primary plan. Notwithstanding the above, this Plan will pay no more than the actual primary plan paid with respect to Expenses Incurred for which this Section applies.

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

Secondary Coverage

Covered Persons or Covered Dependents who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Covered Person or Covered Dependent incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by the Plan.

A provider that accepts the payment from the Plan will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a Covered Person or Covered Dependent and (ii) it shall not

"balance bill" a Covered Person or Covered Dependent for any amount billed but not paid by the Plan.

Coordination with Medicare and Medicaid

(a) Medicare

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

(b) Medicaid

Payment for Expenses Incurred with respect to a Covered Person or Covered Dependent under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Covered Person or Covered Dependent as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act, as in effect on August 10, 1993. In enrolling or in determining or making any payments for Expenses Incurred of a Covered Person or Covered Dependent, the fact that the Covered Person or Covered Dependent is eligible for or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. To the extent that payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Act when the Plan has a legal liability to make payment for the Expenses Incurred constituting such assistance, payment for the Expenses Incurred under this Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Covered Person or Covered Dependent to such payment for such Expenses Incurred.

Termination of Coverage

(a) Termination of Covered Person Coverage:

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

(1) The date the Plan is terminated, or, with respect to a specific

benefit, the date the specific benefit is terminated;

(2) The first of the month following the date the Covered Person ceases to be in a class of employees eligible for coverage;

(3) The date beginning the period for which the Covered Person has failed to make any required contribution for coverage;

(4) For a certified Employee, the date the Employee's contract has expired (unless the Employee's contract is renewed) and for all other Employees the first of the month following the date on which his employment with the Employer terminated; and

(5) The date of the Covered Person's death.

(b) Termination of Covered Dependent Coverage:

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

(1) The date coverage terminates for the Employee upon whom Covered Dependent depends for eligibility;

(2) The date such dependent ceases to be an Eligible Dependent as defined herein;

(3) The date the Plan is modified to terminate dependent coverage;

(4) The date beginning the period for which the Covered Person or Covered Dependent has failed to make any required contribution for dependent coverage, if contributions are required;

(5) The date the dependent child becomes eligible for coverage under this Plan as an Employee;

(6) The date the Plan is terminated, or, with respect to a specific benefit, the date the specific benefit is terminated; and

(7) The date of the Covered Dependent's death.

Extension of Benefits

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

(a) Total Disability

If coverage under the Plan would otherwise terminate with respect to a Covered Person or Covered Dependent who is suffering from Total Disability, benefits will continue to be provided for that person until the earliest of (i) the date the person is covered under another group health plan and no pre-existing condition clause is applicable with respect to that person, (ii) the date the person fails to make any required contribution for continuation of his coverage, (iii) the date the Total Disability ceases, or (iv) twelve (12) months following the beginning of the Total Disability.

(b) Hospital Confinement

If coverage under the Plan would otherwise terminate with respect to a Covered Person or Covered Dependent who is an inpatient in a Hospital, Skilled Nursing Facility or Substance Abuse Treatment Facility, benefits will continue to be provided until the earlier of: (1) date of discharge from the Hospital or other facility, or (ii) the end of the calendar year coverage under the Plan would otherwise terminate.

(c) Death of Covered Person

If coverage under the Plan would otherwise terminate with respect to a Covered Dependent as a result of the death of the Covered Person, benefits will continue to be provided until the earlier of (i) the date the Covered Dependent fails to make any required contribution for continuation of his coverage, or (ii) twelve (12) months following the death of the Covered Person.

(d) State Mandate, Collective Bargaining Agreement or Employer Personnel Policy

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

Qualified Medical Child Support Order

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

(a) An order which purports to be a QMCSO must be served on the Contract Administrator.

(b) The Contract Administrator shall, within twenty (20) days of its receipt of the order, make a preliminary determination as to whether or not the order satisfies the requirements to be a QMCSO. In order to satisfy those requirements, an order must contain at least the following information:

(1) a clause which creates or recognizes the existence of a dependent's right to receive benefits under the Plan;

(2) the name and last known mailing address of the Covered Person with respect to whom the order is issued and each dependent covered by the order;

(3) a reasonable description of the type of coverage to be provided by the Plan to each dependent;

(4) the time period to which the order applies; and

(5) the order does not require the Plan to provide any type or form of benefit not otherwise provided under the Plan.

(c) An order which, in the judgment of the Contract Administrator, does not meet the requirements of a QMCSO shall be returned to legal counsel who prepared the order for revision. Revised orders which are resubmitted shall be considered new orders and shall be reviewed in accordance with the procedures set forth in this Section.

(d) When the Contract Administrator makes a preliminary determination that an order satisfies the requirements of a QMCSO, it shall forward the order to the Employer for review. The Employer shall make the final determination of the status of the order.

(e) The Contract Administrator shall notify all parties involved, including a designated representative of the Covered Dependent, of the Employer's decision and of the respective parties' entitlement to benefits.

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

CONTINUATION OF BENEFITS

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

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

Eligibility to Make Election

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

(a) the Covered Person's death;

(b) termination of the Covered Person's employment or reduction of the Covered Person's hours (whether voluntarily or involuntarily);

(c) divorce or legal separation of the Covered Person and his Spouse;

(d) the Covered Person becoming entitled to Medicare benefits;

(e) a Covered Person's child ceasing to be an Eligible Dependent; or

(f) a proceeding in bankruptcy under Title 11, United States Code, commencing on or after July 1, 1986, with respect to the Employer if the Covered Person is a Retiree.

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

Election Period and Procedure

The election to continue coverage must be made during the period beginning on the day when coverage would otherwise cease under the Plan and ending sixty (60)

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

Benefits

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

Payment for Benefits

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

Duration of Continuation Coverage

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

(a) the date eighteen (18) months after the date of a Covered Person's termination of employment or reduction in hours;

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

(c) the date the Employer ceases to provide any health benefit plan for any of its employees;

(d) the date the Qualified Beneficiary first becomes covered after the date of his election of continuation coverage (as an employee or otherwise) by another group health plan which does not contain any applicable exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary, or the date the Qualified Beneficiary becomes entitled to benefits under Medicare;

(e) the date which is the last day of the period for which the Qualified Beneficiary's Continuation Premium payments have been paid (regardless of any grace period if the Employer establishes such a period) as determined by the Employer; or

(f) in the case of a Qualified Beneficiary who is determined, under Title II or XVI of the Social Security Act ("Act"), to have been disabled at any time during the first sixty (60) days of continuation coverage, the earlier of (i) the date twenty-nine (29) months after the date of occurrence of such event, but only if the Qualified Beneficiary has provided notice of such determination under ERISA Section 606(3) within sixty (60) days of the receipt of the determination notice under the Act and before the expiration of eighteen (18) months from the date of occurrence of the qualifying event, or (ii) the end of the month next following the date of final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.

If more than one event that would entitle the Qualified Beneficiary to elect continuation coverage occurs (as described in the Eligibility to Make Election Section herein), the first occurring of such events shall be the measuring date for purposes of the maximum possible length of continuation coverage under this Section. In addition, the maximum period available for continuation coverage pursuant to the Continuation of Benefits Section is measured from the date of occurrence of the qualifying event specified in the Eligibility to Make Election Section, and is not delayed or extended by any extension of benefits period available pursuant to the Extension of Benefits Section.

Administration

(a) Notice on Death, Termination, Reduction of Hours, or Entitlement to Medicare

Within thirty (30) days of a Covered Person's death, termination of service, reduction of hours, or entitlement to Medicare, the Employer shall inform the Plan Administrator of (i) the Qualified Beneficiaries eligible to elect continuation coverage, (ii) the event precipitating such notice, and (iii) the date of the event. The Employer or Plan Administrator, at the direction of the Employer, shall then notify the Qualified Beneficiaries of their rights to elect pursuant to procedures established by the Employer and applicable law.

(b) Notice of Change in Marital Status or Dependent Status

If a Covered Dependent ceases to be eligible for coverage under the Plan because that person becomes divorced or legally separated from the Covered Person, or if a child of a Covered Person ceases to be eligible for coverage under the Plan because he is no longer an Eligible Dependent, either the Covered Person, the Covered Person's former Spouse or the Covered Person's child must notify the Employer of these events within sixty (60) days of their occurrence in order for the respective Qualified Beneficiary to be eligible to elect continuation coverage. The notice may be provided to the Employer orally or in writing and must disclose (i) the name and Plan identification numbers of the Covered Person and the individuals affected by the event, (ii) the individual’s divorce, separation, or loss of status as an Eligible Dependent, and (iii) the date of such event.

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

(c) Notice of Disability

If a Covered Person or Covered Dependent is determined, under Title II or XVI of the Act to have been disabled at any time during the first sixty (60) days of continuation coverage, the Covered Person or Covered Dependent as the case may be must notify the Employer of the determination under the Act within sixty (60) days of the receipt of the determination notice under the Act and before the expiration of eighteen (18) months from the date of occurrence of the termination of employment or reduction in hours. The notice must be provided to the Employer in writing and must disclose (i) the name and Plan identification number of the disabled Covered Person or Covered Dependent, and (ii) the determination notice provided pursuant to the Act to the disabled Covered Person or Covered Dependent. The Qualified Beneficiaries must also notify the Employer in writing within thirty (30) days of the date of any final determination

under the Act that the Covered Person or Covered Dependent is no longer disabled. The notice shall disclose (i) the name and Plan identification number of the disabled Covered Person or Covered Dependent, and (ii) the final determination Notice provided pursuant to the Act that the person is no longer disabled.

(d) Notice of Coverage Under Group Health Plan or Entitlement to Medicare

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

(e) General

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

(2) Notices to Employer. Notices to the Employer shall be provided to the person or organizational unit of the Employer that customarily handles employee benefits matters of the Employer.

(3) Current Addresses. The notification of election rights under COBRA will generally be made by U.S. Mail to the Qualified Beneficiary's last known address. As a result, it is important for each Covered Person and Covered Dependent to timely provide the Employer with his current mailing address.

(4) Interpretation. In the event of any inconsistency or omission, this Section and the applicable provisions of the Plan shall be construed, interpreted, and administered in a manner which meets the minimum requirements of COBRA.

ILLINOIS MUNICIPAL RETIREMENT FUND ("IMRF") BENEFITS

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

(a) A Full-Time Employee who is removed from the Employer's payroll due to retirement or disability, and who immediately becomes entitled to receive an IMRF pension or disability benefit;

(b) The Covered Dependents of such a retired or disabled Employee which are covered under the Plan on the day before such Employee is removed from the Employer's payroll; and

(c) The surviving Spouse of such a retired or the Spouse or disabled Employee, but only if the Spouse:

(1) is covered under the Plan on the death;

(2) is eligible for IMRF benefits; and

(3) elects to receive an IMRF surviving Spouse pension (rather than a lump sum death benefit).

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

(a) The date the retired or disabled Employee:

(1) again becomes an active participant in IMRF;

(2) is convicted of an IMRF job related felony;

(3) dies; or

(4) fails to pay any required contribution for coverage;

(b) The date a disabled Employee is no longer entitled to IMRF benefit payments or takes a separation refund;

(c) The date a Spouse or child ceases to be an Eligible Dependent;

(d) The date the surviving Spouse:

(1) remarries prior to age fifty-five (55);

(2) dies; or

(3) fails to pay any required contribution for coverage; or

(e) The date the Employer terminates medical coverage for all Employees.

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

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

(a) verify the Employee's or surviving Spouse's eligibility for IMRF benefits; and

(b) send the Employee or surviving Spouse a notice of this continuation privilege (including the cost for continued Plan coverage).

For a disabled Employee, this continuation right will apply only if, after reviewing his or her medical information, the IMRF determines that IMRF disability benefits are payable. For a surviving Spouse of a disabled Employee, this continuation right will

apply only if the Spouse elects a monthly annuity (rather than a lump sum death benefit).

To continue Plan coverage, the retiree, disabled Employee, or surviving Spouse must send the Employer written election and first payment within thirty-one (31) days after receipt of notice. In some cases, the individual may sign written authorization for IMRF to deduct future monthly payments for the cost of Plan coverage from his or her recurring IMRF benefit payments.

MILITARY LEAVE

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

Election and Duration of Coverage

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

(a) the twenty-four (24) month period beginning on the date on which the Covered Person's military leave began; or

(b) the day after the date on which the Covered Person fails to apply for or return to a position of employment with the Employer following the expiration of the leave as set forth in Section 4312(e) of USERRA.

Benefits

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

Payment for Benefits

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

Employee Returning From Military Leave

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

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

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

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

(A) Coverage shall cease for a Covered Person (and his Covered Dependents) for the duration of the leave if at any time the Covered Person is more than thirty (30) days late in paying any required contribution.

(B) A Covered Person who declines coverage during the leave or whose coverage is terminated as a result of his failure to pay any required contributions shall, upon return from the leave, be entitled to be reinstated to the Plan on the same terms as prior to taking the leave, without any qualifying period, physical examination, or exclusion of pre-existing conditions.

(C) With respect to an FMLA leave, if a Covered Person who is a Key Employee does not return from leave when notified by the Employer that substantial or grievous economic injury will result from his reinstatement, the Key Employee's entitlement to Plan benefits continues unless and until the Covered Person advises the Employer that he/she does not desire restoration to employment at the end of the leave period, or the leave entitlement is exhausted, or reinstatement is actually denied.

(D) Any portion of the cost of coverage which had been paid by the Covered Person prior to the leave, must continue to be paid by the Covered Person during the leave. If the cost is raised or lowered during the leave, the Covered Person shall pay the new rates. If the leave is unpaid, the Covered Person and the Employer shall negotiate a reasonable means for paying the Covered Person's portion of the cost.

(E) If the Employer provides a new health plan or benefits or changes the health benefits or Plan while the Covered Person is on leave, the Covered Person is entitled to the new or changed plan and benefits to the same extent as if the Covered Person were not on leave.

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

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

(H) A FMLA leave and VESSA leave shall run concurrently to the extent permitted by law.

MISCELLANEOUS

Nonalienation of Benefits

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

Invalid Provision

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

Governing Law

The interpretation of the terms and provisions of this Plan shall be governed by the Laws of the State of Illinois where it has been executed, except where preempted by federal law. The Plan shall comply with the requirements of 42 USC 300gg-5(a).

Amendment/Termination

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

Exclusive Benefit/Legal Enforceability

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

INTERPRETATION OF THE PLAN

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Person's or Covered Dependent's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable. Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person or Covered Dependent is entitled to them.

DEFINITIONS

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

(1) an organized medical staff of Physicians;

(2) permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;

(3) continuous Physician and Registered Nursing services whenever a patient is in the facility; and

(4) which does not provide services or other accommodations for patients to stay overnight.

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

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

Covered Person: Means an eligible Employee or former Employee whose coverage became effective and has not terminated.

Eligible Dependent: Means an Employee's:

(1) Spouse;

(2) child less than twenty-six (26) years of age;

(3) unmarried child between twenty-six (26) and thirty (30) years of age if a Military Veteran; or

(4) any unmarried child twenty-six (26) years of age or over who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who is chiefly dependent upon the Employee for support and maintenance;

but excludes the following:

(a) any person who is not a resident within the United States of America;

(b) any person who is covered under this Plan as an Employee;

(c) any person who is on active duty in any military, naval, or air force of any country; or

(d) any Spouse of an Employee who is legally separated from the Employee.

A "child" of the Employee includes a step-child living with the Employee in a normal parent-child relationship, adopted child, child in the custody of an Employee while adoption proceedings with respect to that child by the Employee are pending, or child

for whom the Employee is appointed legal guardian. A grandchild or foster child shall not be an Eligible Dependent unless such child is legally adopted or adoption proceedings by the Employee are pending with respect to that child.

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

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

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

Employee: Means a person employed by the Employer.

Employer: Means Metamora Township High School District No. 122.

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

Full-Time Employee: Means (i) a certified Employee who is scheduled to work at least thirty (30) hours per week during the school year or (ii) a non-certified Employee who is scheduled to work at least thirty (30) hours per week during the school year; who is on the regular payroll of the Employer, but specifically excluding temporary, seasonal or part-time employees.

Habilitative Services: Means occupational therapy, physical therapy, speech therapy, and other services prescribed by a treating Physician pursuant to a treatment plan to enhance the ability of a child to function with a congenital, genetic, or early acquired disorder, provided the treatment is administered by a Physician, licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, licensed nurse, licensed optometrist, license nutritionist, licensed social worker, or licensed psychologist upon the referral of a Physician licensed to practice medicine in all its branches.

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

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

Immediate Family: Means a person's Spouse and children.

Injury: Means accidental bodily injury of a Covered Person or Covered Dependent which results from an accident occurring while the Plan is in force with respect to that Covered Person or Covered Dependent, and which results in loss covered by the Plan. All Injuries sustained by a Covered Person or Covered Dependent in connection with a single accident shall be considered one Injury.

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

(1) is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;

(2) has special supplies and equipment, necessary for such care and treatment, available on a standby basis for immediate use; and

(3) provides Room and Board and constant observation and care by Registered Nurses or other specially trained Hospital personnel.

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

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

Marriage: Means either (i) a legal marriage between two persons, or (ii) a legal relationship between two (2) persons, of either the same or opposite sex, established or recognized as such by the Illinois Religious Freedom Protection and Civil Union Act.

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

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

Military Veteran: Means an Illinois resident who served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States (including the National Guard) who has received a release or discharge other than a dishonorable discharge. To be considered a Military Veteran by the Plan, the veteran must submit to the Contract Administrator a form approved by the Illinois Department of Veteran's Affairs stating the date on which the veteran was released from service.

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

Oral Surgery: Means:

(1) surgical removal of impacted teeth;

(2) excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

(3) surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth; and

(4) excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

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

Out-Patient Treatment: Means treatment at a Hospital not requiring confinement and not involving a charge for Room and Board.

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

Preventative Care: Means:

(a) Evidence based items or preventive services that have an “A” or “B” rating from the United States Preventive Services Task Force;

(b) Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

(c) Evidence-informed preventive care services and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents;

(d) Additional Preventive care and screenings not described above as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for women (including those adopted on August 1, 2011); and

(e) The current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention, other than those issued in or around November 2009.

Except as provided in subsection (d) above, Preventative Health Services shall not include those services until federal guidelines under the Affordable Care Act otherwise requires them to be covered.

Reasonable and Customary: Means with respect to a preferred provider the preferred provider negotiated maximum charge amount. The Reasonable and Customary amount means with respect to a non-preferred provider for non-emergency department treatment the lesser of the provider's billed charge or a reasonable compensation amount. The reasonable compensation amount is determined by Data iSight in accordance with its standard practices and procedures and based on one or more of the following:

(a) Using current publicly-available data reflecting fees typically reimbursed to providers for professional services, adjusted for geographical differences;

(b) Using current publicly-available data reflecting the costs for facilities providing the same or similar services, adjusted for geographical differences plus a margin factor; or

(c) Using an amount negotiated with the provider for the specific services provided.

For emergency department treatment the Reasonable and Customary amount with respect to a non-preferred provider shall mean the greater of:

(a) The amount calculated using the above methodology;

(b) The median rate negotiated with preferred providers; or

(v) The fee paid by Medicare for the same services.

The Reasonable and Customary amount for outpatient dialysis treatment is determined in accordance with the Dialysis Treatment – Outpatient Section.

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

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

Sickness: Means disease, mental, emotional or nervous disorders of a Covered Person or Covered Dependent which first manifests itself while the Plan is in force with respect to that Covered Person or Covered Dependent, and which results in loss covered by the Plan. It also includes the pregnancy of a Covered Person or Covered Dependent which first manifests itself while the Plan is in force with respect to that Covered Person or Covered Dependent, and which results in loss covered by the Plan.

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

(1) is approved by and is a participating Skilled Nursing Facility of Medicare;

(2) has organized facilities for medical treatment and provides twenty-four (24) hour nursing service under the full-time supervision of a Physician or Registered Nurse;

(3) maintains daily clinical records on each patient and has available the services of a Physician under an established agreement;

(4) has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one Physician.

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

Spouse: Means a party to a Marriage.

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

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

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

Total Disability: Means the Covered Person is unable, as a result of a non-occupational Sickness or Injury, to perform each of the main duties of such person's occupation with the Employer. A Covered Dependent will be considered to be suffering from Total Disability, if because of a non-occupational Injury or Sickness, he is prevented from engaging in all normal activities of a person of like age and sex who is in good health.

METAMORA TOWNSHIP HIGH SCHOOL DISTRICT NO. 122

By:_____

Its:_____

Dated:_____

515-138

ADDENDUM A

PRESCRIPTION DRUG CARD PLAN

BENEFITS

for

EMPLOYEES OF

METAMORA HIGH SCHOOL

I. INTRODUCTION:

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

II. ELIGIBILITY AND PLAN PARTICIPATION:

1. Eligibility Requirements.

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

2. Participation.

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

Ill. DEFINITIONS:

CODE Means the Internal Revenue Code of 1986, as amended from time to time.

COPAYMENT AMOUNT - Means the amount which an Eligible Person is required to pay for a Covered Drug in accordance with the Health Plan.

COVERED DRUG Means any Prescription Legend Drug and such other drugs as may be set forth from time to time on the list maintained by the Employer and incorporated herein by reference, when ordered by a Physician by means of a Prescription Order.

DEPENDENT - Means an individual who meets the definition of a dependent as set forth in the Health Plan.

ELIGIBLE PERSON - Means an individual described in an Identification Card who is entitled to Covered Drug expense benefits in accordance with and under the terms of the Plan, and his/her Dependents.

EMPLOYEE - Means a person employed by Metamora Township High School District No. 122.

EMPLOYER - Means Metamora Township High School District No. 122.

HEALTH PLAN - Means the Metamora High School Health Benefit Plan established and maintained by the Employer.

IDENTIFICATION CARD - Means a card or cards issued as proof of eligibility for Covered Drug expense benefits in accordance with and under the terms of the Plan.

PARTICIPANT - Means an Employee who has satisfied the Eligibility Requirements and has elected to participate in the Plan.

PHARMACY - Means a pharmacy doing business as a licensed pharmacy under an applicable state license or registration member and which has entered into a Prescription Drug Agreement with the Contract Administrator.

PRESCRIPTION LEGEND DRUG - Means any medicinal substance the label of which is required by the Federal Food, Drug and Cosmetic Act to bear the legend-"Caution: Federal Law prohibits dispensing without prescription."

PRESCRIPTION ORDER - Means a request for medication by a Physician.

PHYSICIAN - Means a doctor of medicine, a doctor of osteopathy, a doctor of dental surgery, a doctor of dental medicine or a podiatrist, who is legally licensed to prescribe medications within the scope of that license.

IV. BENEFITS:

Each Eligible Person may purchase Covered Drugs from a Pharmacy by presenting their Identification Card and paying the applicable Copayment Amount. Covered Drugs may be purchased from those Pharmacies listed on the Participating Pharmacy Listing, a copy of which may be reviewed at the location of the Contract Administrator, or at such other sites as the Contract Administrator deems necessary. Pharmacies may be added to or deleted from the Participating Pharmacy Listing from time to time.

Covered Drugs are obtained from the Mail Order Program by completing the Registration & Prescription Order Form available from the Contract Administrator and mailing the Form to the mail order vendor.

V. PENALTIES FOR IMPROPER USE:

Eligible Persons may not use their Identification Cards to obtain Covered Drugs after having received notification of the cancellation of their benefits or for persons other than Eligible Persons. Any Eligible Person who makes an improper use of his Identification Card may be guilty of a Class C misdemeanor in accordance with the provisions of Section 512-8(c) of the Illinois Insurance Code and may be liable to the Administrator or Employer for amounts the Contract Administrator or Employer has paid as a result of any improper use of his Identification Card.

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

VI. CLAIMS:

1. Filing of a Claim.

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

(a) the name of the patient;

(b) the Employee's name and social security number;

(c) the name of the Pharmacy dispensing the drug;

(d) the name, strength, and quantity of the drug dispensed;

(e) the date the drug was dispensed; and

2. Denial of Claims.

If your claim for benefits is denied, the Claims Section of the Health Plan sets forth your rights regarding Claims Review Procedures.

VII. GENERAL:

1. Questions/Forms/Information.

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

2. Nondiscrimination.

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

ADDENDUM B

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

ALABAMA - Medicaid	GEORGIA - Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
ALASKA - Medicaid	INDIANA - Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO - Medicaid	IOWA - Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

FLORIDA - Medicaid	KANSAS - Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY - Medicaid	NEW HAMPSHIRE - Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA - Medicaid	NEW JERSEY - Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE - Medicaid	NEW YORK - Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS - Medicaid and CHIP	NORTH CAROLINA - Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA - Medicaid	NORTH DAKOTA - Medicaid
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI - Medicaid	OKLAHOMA - Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

MONTANA - Medicaid	OREGON - Medicaid
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA - Medicaid	PENNSYLVANIA - Medicaid
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA - Medicaid	RHODE ISLAND - Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA - Medicaid	VIRGINIA - Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	WASHINGTON - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS - Medicaid	WEST VIRGINIA - Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH - Medicaid and CHIP	WISCONSIN - Medicaid and CHIP
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT - Medicaid	WYOMING - Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Service Agency:

C.L. Wyman & Associates, Inc.
Timothy J. Wyman, Vice President
230 SW Adams Street, Suite 501
Peoria, IL 61602
Ph. (309) 685-8222
Fax (309) 685-8324