PEKIN PARK DISTRICT
HEALTH AND WELFARE BENEFIT PLAN

Document and Summary Plan Description
Effective: OCTOBER 1, 2015

Table of Contents

INTRODUCTION AND PURPOSE and GENERAL PLAN INFORMATION.....5
Introduction and Purpose 5
SCHEDULE OF BENFITS.....8
DEFINITIONS.....10
ELIGIBILITY AND EFFECTIVE DATE FOR COVERAGE 30
Eligibility for Employee Coverage 30
Effective Date for Employee Coverage 30
Special Enrollment Periods.....31
For Persons Who Previously Declined Coverage 31
Due to a Change in Family Status.....31
Qualified Medical Child Support Order.....31
TERMINATION OF COVERAGE 33
Continuation During Family and Medical Leave.....34
Employees on Military Leave 35
Illinois Municipal Retirement Fund ("IMRF") Benefits.....35
AMOUNT OF BENEFIT FOR COVERED HEALTH EXPENSES 37
Preventative Care 37
Benefit for Covered Health Expense by a Preferred Provider (PPO) 37
Benefit for Covered Health Expense for Emergency Services Provided in a Hospital Emergency Room.....38
Benefit for Covered Health Expenses Provided by a Non-Preferred Provider.....38
Use of Non-Preferred Providers.....39
Benefit for Emergency Services Provided by a Non-Preferred Provider.....39
Benefit for Specialty Physician Services by a Non-Preferred Provider.....39
Benefit for Self-Injected Medications Other Than Insulin.....39
COVERED HEALTH EXPENSES UNDER THIS PLAN 40
TRANSPLANT BENEFIT 45
PRESCRIPTION MEDICATION BENEFIT 46
Amount of Benefit.....46
Allowable Covered Prescription Expense.....46
Prescriptions Purchased at a Retail Pharmacy 47
Prescriptions Purchased from the Mail Service Program.....47
How to file a Claim 48
Prescription Drug Card Exclusions.....48

EXPENSE NOT COVERED BY THE PLAN 49
PRE-CERTIFICATION OF SERVICES 52
Services Requiring Pre-Certification by Utilization Review 52
Non-Emergency Hospitalization, Surgeries, and Procedures 52
Medical Emergency 52
Making the Call 53
Pre-certification Process 53
Medical Necessity and Appropriateness 53
Right to Appeal 53
Failure to Precertify 53
CASE MANAGEMENT 54
FILING A CLAIM, CLAIM PROCEDURES, APPEAL PROCEDURES 54
COORDINATION WITH MEDICARE AND MEDICAID 66
COORDINATION OF BENEFITS 67
HEALTH INSURANCE CONTINUATION COVERAGE RIGHTS UNDER COBRA 68
GENERAL PROVISIONS 71
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT 73
PLAN ADMINISTRATION 77
HIPAA PRIVACY 79
WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 81
ANNUAL NOTICE TO HEALTH PLAN PARTICIPANTS 81
THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 82
ANNUAL NOTICE TO HEALTH PLAN PARTICIPANTS 82

ESTABLISHMENT OF THE PLAN

ADOPTION OF THE PLAN DOCUMENT AND SUMMARY DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by PEKIN PARK DISTRICT (the "Sponsor") as of October 1, 2015 hereby sets forth the provisions of the PEKIN PARK DISTRICT Health and Welfare Benefit Plan (the "Plan").

Effective Date

The Plan Document is effective as of the date first set forth above, and any amendment is effective as of the date set forth in the amendment.

Adoption of the Plan Document

PEKIN PARK DISTRICT, as the settler of the Plan, hereby adopts this Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Document to be executed.

PEKIN PARK DISTRICT

By: Cameron Bettin

Name: CAMERON BETTIN

Date: 3-10-16

Title: EXECUTIVE DIRECTOR

INTRODUCTION AND PURPOSE and GENERAL PLAN INFORMATION

Introduction and Purpose

PEKIN PARK DISTRICT has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Participants in the Plan may be required to contribute toward their benefits.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for hospital and medical benefits. The Plan Document is maintained by PEKIN PARK DISTRICT and may be inspected at any time during normal working hours by any Participant.

General Information

Name of Plan:	**PEKIN PARK DISTRICT Health and Welfare Benefit Plan**
Plan Sponsor:	**PEKIN PARK DISTRICT 1701 Court Street Pekin, IL 61554 309-353-5358**
Plan Administrator: (Named Fiduciary)	**PEKIN PARK DISTRICT**
Plan Sponsor ID No.	**37-6002173**
Source of Funding:	**Self-Funded**
Plan Status:	**Non-Grandfathered**
Plan Year:	**October 1 through September 30**
Plan Type:	**Medical and Prescription Drug**
Effective Date:	**October 1, 2015**
Third Party Administrator:	**Group Plan Solutions Benefit Administration, a Division of Pekin Insurance 2505 Court Street Pekin, IL 61558 Phone: 888-301-0747 Fax: 309-478-2912 Email: inquiry@groupplansolutions.com Website: www.groupplansolutions.com**
Utilization Review:	**Medical Cost Management 24-hour Pre-certification 888-641-5304**

Pharmacy Benefit Manager:	**MagellanRx** **Customer Service: 800-424-5828** **Website:** www.magellanrx.com
Provider Networks:	**PHN – Progressive Health Network and First Choice** **Customer Service: 888-301-0747** **Website: www.groupplansolutions.com**
COBRA Notice:	**Group Plan Solutions Benefit Administration, a Division of Pekin Insurance** **COBRA** **2505 Court Street** **Pekin, IL 61558** **Phone: 888-301-0747** **Fax: 309-478-2912** **Email: inquiry@groupplansolutions.com** **Website: www.groupplansolutions.com**
Agent for Service of Process:	**PEKIN PARK DISTRICT** **1701 Court Street** **Pekin, IL 61554**

Legal Entity and Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between First Federal Savings & Loan Association of Central Illinois and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the First Federal Savings & Loan Association of Central Illinois or to interfere with the right of the to discharge any Employee at any time.

Mental Health Parity

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations.

Applicable Law

This is a self-funded benefit plan. The Plan is funded with employee and/or employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right:

- to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents
- to make determinations in regards to issues relating to eligibility for benefits
- to decide disputes that may arise relative to a Plan Participant's rights, and
- to determine all questions of fact and law arising under the Plan.

PPO Schedule of Benefits
Effective 10/01/2015
Pekin Park District

Expenses must be eligible under the plan, medically necessary and the most cost-effective medically appropriate care.

Plan Type - PPO		In Network	In Network	Out of Network
		Tier 1	Tier 2	Tier 3
Deductible per Calendar Year	Individual	$500	$1,000	$5,000
	Family	$1,500	$3,000	$15,000
	Deductibles must be met before benefits are paid, except where co pays apply. Tier 1 and Tier 2 deductible accumulate to each other. All individual deductible amounts will satisfy the family deductible, but no one participant will be required to pay more than the individual deductible amount. Deductible amounts accumulate separately for In and Out of Network benefits. Where co insurance is listed it is assumed that deductible is paid first.			
Out of pocket: maximum per Calendar year	Individual	$1,000	$2,000	$10,000
	Family	$3,000	$6,000	$30,000
	Out of pocket maximum includes annual medical deductible, copays, coinsurance and prescription drug copays. All individual out of pocket amounts will satisfy the family out of pocket, but no one participant will be required to pay more than the individual out of pocket amount. Out of Pocket amounts accumulate separately for In and Out of Network benefits.			
Lifetime Maximum Benefits		Unlimited	Unlimited	Unlimited

Precertification Requirements

Your plan requires that certain services be precertified. It is your responsibility to call Medical Cost Management (MCM) 888-641-5304 to pre-certify your service or confirm that your service has been precertified, on your behalf, by your medical provider.
Failure to obtain precertification for your services will result in monetary penalties or exclusion of coverage.

Services Requiring Precertification include but may not be limited to:

2 days advanced precertification for all scheduled inpatient admissions, overnight observation stays.
2 days advanced precertification for scheduled, non emergency High Tech Diagnostic Services (i.e.: but not limited to MRI/MRA, CT, PET)
Urgent/Emergency Inpatient admissions stays require precertification within 2 days.
Please refer to your Health Plan for further details.

Case Management

Your plan requires that certain services have Case Management Prior Authorization.
It is your responsibility to call the Case Manager at 888-301-0747, extension 3155

Case Management can provide assistance with the following services:

Durable medical equipment, injectable medications (i.e. Lovenox, Enbrel, Humira, Avonex, Byetta, etc.), home health care, orthotics, prosthetics, most medical supplies, chemotherapy, transplants, skilled nursing and hospice, insulin pump, diabetic or ostomy supply.
If you or a family member are faced with a complex or long-term health concern such as cancer, diabetes, amputation, organ transplant, kidney failure/dialysis, or any other serious health issue, our Case Management Services can help you with many of your needs.
Refer to your Health Plan for full listing or contact us for assistance.

Network

This is a PPO Plan which contains a Network Provider Organization based on your location. ***Please refer to ID card for correct network identification.***

Tier 1	PHN Network	888-301-0747 or go online to www.groupplansolutions.com
Tier 2	First Choice	888-301-0747 or go online to www.groupplansolutions.com

On Line Tools

View your claim information securely on line, anywhere, anytime, with Group Plan Solutions at **www.groupplansolutions.com**

To find a Provider
Go to Member> Select Find a Provider
Click the Find a Provider button
Please reference your ID card to determine your correct network.

To view Claim Information
Go to Member> Select Claim Inquiry.
Click the Health Claim/Webeci button.
Log in with your user name and password

Still need help? Call us at 888-301-0747
Be sure to check out the other great tools and resources available at **www.groupplansolutions.com**

Contact Numbers

Group Plan Solutions	888-301-0747	FAX 309-478-2912
Prescription Coverage	888-301-0747	EXT: 2459
Additional ID Cards	888-301-0747	EXT: 2758
Case Management Prior Authorization	888-301-0747	EXT: 3155
Precertification: MCM	888-641-5304	
PPO Network Questions:	888-301-0747	EXT: 2758

PPO Schedule of Benefits
Effective 10/01/2015
Pekin Park District

Expenses must be eligible under the plan, medically necessary and the most cost-effective medically appropriate care.

Where co insurance is listed it is assumed that deductible is paid first

Category	Description	In Network Tier 1 - Contracted	In Network *Tier 2	Out of Network
Preventative Care		You Pay	You Pay	You Pay
	Routine Preventive Care office visits	$0	$0	50% co insurance
	Preventive lab and x-ray	$0	$0	50% co insurance
	Pap smear and mammogram	$0	$0	50% co insurance
	Prostate screening	$0	$0	50% co insurance
	Routine Immunizations	$0	$0	50% co insurance
Physician Services				
	Office visits- evaluation and management services *__Effective 1/1/2016 - Tier 1 Office Visit copays will be: $25 for Primary Care Provider and $50 for a Specialist.__	$40 copay Primary Care Provider/$65 copay Specialist until 12/31/15*	$40 copay Primary Care Provider/$65 copay Specialist	50% co insurance
	Diagnostic Procedures and diagnostic therapeutics	5% co insurance	25% co insurance	50% co insurance
	High Tech Diagnostic Service (i.e. MRI, MRA, CT and PET) - **Precertification required**	5% co insurance	25% co insurance	50% co insurance
	Diagnostic lab and x-ray	5% co insurance	25% co insurance	50% co insurance
Facility Services				
	Inpatient Hospital Stay - **Precertification required**	5% co insurance	25% co insurance	50% co insurance
	High Tech Diagnostic Services (i.e. MRI/MRA, CAT Scan, PET Scan) - **Precertification required**	5% co insurance	25% co insurance	50% co insurance
	Diagnostic lab and x-ray	5% co insurance	25% co insurance	50% co insurance
	Outpatient - Diagnostic and Surgery	5% co insurance	25% co insurance	50% co insurance
	Emergency Room Services/ includes professional fee - co pay waived if admitted.	$250 copay		
	Emergency Room Services/Non Emergent -deductible does apply	5% co insurance	25% co insurance	50% co insurance
Other Medical Services				
	Urgent Care Facility	$80 copay	$80 copay	50% co insurance
	Emergency Medical Transportation	$150 copay		
	Maternity Services	5% co insurance	25% co insurance	50% co insurance
	Therapy - Outpatient. Occupational, Speech, Physical	5% co insurance	25% co insurance	50% co insurance
	Inpatient Rehabilitation Services	5% co insurance	25% co insurance	50% co insurance
	Chiropractic Treatment/Spinal Manipulation-limited to $1000 per plan year	50% no deductible	50% no deductible	50% no deductible
	Durable Medical Equipment Case - **Management Prior Authorization required.**	5% co insurance	25% co insurance	50% co insurance
	Prosthetic - must be medically necessary.	5% co insurance	25% co insurance	50% co insurance
	Hospice care	25% co insurance	25% co insurance	50% co insurance
	Home Health Care - Limited to 40 visits per calendar year. **Case Management Prior Authorization is required.**	5% co insurance	25% co insurance	50% co insurance
	Skilled Nursing Facility - Short Term non custodial care in a skilled nursing facility. Limited to 90 days per calendar year. **Case Management Prior Authorization is required.**	25% co insurance	25% co insurance	50% co insurance
	Organ Transplants - **Case Management Prior Authorization is required**.	Office Visit and Hospital Coinsurance apply. Center of Excellence requirement as stated in the Covered Health Expenses		
	Infertility Services	5% co insurance	25% co insurance	50% co insurance
	TMJ	Not covered	Not covered	Not covered
	Private Duty Nursing	Not covered	Not covered	Not covered
	Specialty Injectable Drugs - **Case Management Prior Authorization is required.**	25% co insurance		
Mental Health, Chemical and Alcohol Dependency				
	Inpatient Hospital stay - **Precertification is required.**	5% co insurance	25% co insurance	50% co insurance
	Outpatient services	5% co insurance	25% co insurance	50% co insurance
	Office therapy- Evaluation and Management services * **Effective 1/1/2016 - Office Therapy Tier 1 copay will be $25**	$40 copay until 12/31/15*	$40 copay	50% co insurance

Deductible does not apply to the Pharmacy Benefits.

Pharmacy	Generic/Preferred Brand &Non- Preferred co pay
Magellan Network Retail and Mail Order - 1 to 34 day supply	$7/$35/$70
Magellan Network Retail and Mail Order - 35 to 60 day supply	$14/$70/$140 - (2 times 30 day copay)
Magellan Network Retail and Mail Order - 61 to 90 day supply	$19.25/$96.25/$192.50 - (2.75 times the 30 day copay)
Magellan Network Retail - OTC (Only OTC on the PBM OTC list covered)	$0
Specialty Rx - limited a 30 day supply	$140

Insulin is the only injectable processed under the drug card. All other injectable will be processed under the medical coverage and require Case Management Prior Authorization.

Self Injectable Medications - covered under the medical coverage, Case Management Prior Authorization.

Prescription Benefit Program

Your prescription benefit program is managed through Partner Rx

View Formulary and to Locate a Pharmacy	www.partnersrx.com
Customer Service	800-711-4550
Mail Order	800-491-7997

* Hospital Services and Specialist Providers not available at PHN/Pekin Hospital will be covered at the Tier 1 deductible, coinsurance, copay and out of pocket max when covered individual receive those services at a UnityPoint Methodist/Proctor Hospitals or a First Choice Network provider for a Specialist.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; however they may be used to identify ineligible expenses. Please refer to the appropriate sections of the Plan Document for that information.** There are also definitions located in other sections of this Plan Document.

ACTIVE FULL-TIME EMPLOYEE

Means a person employed by PEKIN PARK DISTRICT on a permanent full-time basis. The person must work at least 30 hours per week.

ADVERSE BENEFIT DETERMINATION

Adverse Benefit Determination shall mean any of the following:

- A denial in benefits;
- A reduction in benefits;
- A rescission of coverage;
- A termination of benefits; 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 Claimant's eligibility to participate in the Plan.

APPEAL

Means a review of an adverse benefit determination by the Third Party Administrator, as required under this Plan's claims and internal appeals procedures.

Once an authorized representative is appointed, the Third Party Administrator will direct all information and notification regarding the claim to the authorized representative. You will be copied on all notifications regarding decisions, unless you provide specific written direction otherwise.

APPROVED CLINICAL TRIAL

A phase I, phase II, phase III, or phase IV Clinical Trial

- Conducted in relation to the prevention, detection, or Treatment of cancer or other life-threatening disease or condition; and
- is one of the following
    - Federally funded trials
    - The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.

    - A bona fide Clinical Trial Cooperative group or center of any of the entities described in clauses 1) through 4) above or the Department of Defense or the Department of Veterans Affairs.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
- In any of the following clauses below if the following conditions are met: The study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer reviews of studies and investigations used by the National Institutes of Health and assures unbiased reviews of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
    - The Department of Veterans Affairs
    - The Department of Defense
    - The Department of Energy; or.
- The study or investigation is conducted under an investigational new drug application review by the Food and Drug Administration; or
- The study or investigation is a drug trial that is exempt from the investigational new drug application requirements.

Life-threatening condition
Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Qualified Individual
A Participant who meets the following conditions:

- The individual is eligible to participate in an approved Clinical Trial according to the trial protocol with respect to Treatment of cancer or other life-threatening diseases or conditions.
- Either:
    - the referring health care provider has concluded that the Participant's participation in the clinical trial would be appropriate based upon the Participants meeting the conditions described in paragraph above; or
    - the Participant provides medical and scientific information establishing that participation in such trial would be appropriate based upon the Participants meeting the conditions described above.

Routine Patient Costs
All items and services that are typically covered by the Plan for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include:

- the investigational item, device, or service, itself;
- items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Clinical Trial participation requires Case Management Prior Authorization.

AUTHORIZED REPRESENTATIVE

Means:

- a person to whom you have given express written consent to represent you in an external review, and includes your health care provider, or
- a person authorized by law to provide substituted consent for you, or
- your health care provider when you are unable to provide consent.

An Appointment of Authorized Representative form may be obtained from the Third Party Administrator. The completed form must be submitted to our Third Party Administrator at:

Group Plan Solutions
2505 Court Street
Pekin, IL 61558
FAX # 309-478-2912
Email Address: healthclaimappeal@groupplansolutions.com

An assignment for purposes of payment does not constitute appointment of an authorized representative under these claim procedures.

BENEFIT PERIOD

The 12 month period during which deductible and coinsurance amounts apply. It begins on January 1 of a year and ends on December 31 of the year.

BEST EVIDENCE

Means evidence based on:

- randomized clinical trials; or
- if randomized clinical trials are not available, then cohort studies or case-control studies; or
- if the above-listed items are not available, then case-series; or
- if none of the above-listed items are available, then expert opinion.

CALENDAR YEAR

The 12 month period during which deductible and coinsurance amounts apply. It begins on January 1 of the year and ends on December 31 of the year.

CHILD, CHILDREN

Means the covered employee or covered employee spouses:

- natural born child;
- legally adopted child or child in the custody of the Participant employee or employee's spouse while adoption proceedings are pending with respect to that child;
- step child; or
- any other child that has been declared the legal responsibility of the covered employee or covered employee's spouse.

The child must be under 26 years of age.

It also means the covered employee or covered employee's spouse's child who is 26 years of age or older, if the child meets the definition of Total Disability. The child must have become incapable before he/she became 26 years of age.

CLAIM

Means any request for a Plan benefit or benefits made in accordance with the claim procedures. A communication regarding benefits that is not made in accordance with the claim procedures will not be treated as a claim.

CLAIMANT

Means a Participant person who makes a request for a Plan benefit or benefits in accordance with the claim and appeals procedures. Any reference to claimant in the section titled CLAIM AND APPEAL PROCEDURES also refers to an authorized representative of the Participant person.

COINSURANCE

Means the designated percentage that the Plan will pay per Participant per benefit period in excess of any applicable deductible for covered expense. The percentages are shown on your Schedule of Benefits. The In-network coinsurance amount applies to covered services provided by a Preferred Provider. The Out of Network coinsurance amount applies to covered services provided by a Non-Preferred Provider.

COMPLICATIONS OF PREGNANCY

Pregnancy complicated by concurrent disease or abnormal conditions significantly affecting usual medical management, such as, but not limited to:

- extra-uterine pregnancy;
- severe toxemic disorders;
- severe puerperal sepsis;
- spontaneous miscarriage;
- severe hemorrhage;
- any complications of pregnancy requiring delivery by cesarean section.

Complication of pregnancy does not include:

- false labor;
- occasional spotting;
- physician prescribed rest;
- morning sickness;
- induced abortion;
- elective cesarean section;
- maternal age;
- repeat cesarean section, unless necessary because of existing medical complications.

CONCURRENT CARE CLAIM

Means a claim where an ongoing course of treatment that has been approved will be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims:

a. Where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; or
b. Where an extension is requested beyond the initially approved period of time or number of treatments.

COPAY

The specific dollar amount a Participant is required to pay towards covered expenses. Copay amounts vary based on the service and provider and are shown on the Schedule of Benefits

COVERED EXPENSE

The medically necessary, regular, reasonable & customary charges for medical services and supplies that are incurred:

- By a Participant while this coverage is in force; and
- Before this coverage ends; and
- For the treatment of an illness or injury.

In determining whether an expense is a covered expense the Plan will consider:

- The definitions, provisions, limitations and exclusions in the plan document; and
- Clinical coverage guidelines and medical policies as posted on the public website of the Third Party Administrator; and
- Medical peer reviews and recommendations provided by nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

CUSTODIAL CARE

Care which is primarily for the purpose of meeting personal needs. It can be provided by persons without professional skills or training. Examples are help in walking, getting in and out of bed, bathing, eating, dressing, and taking medicine. Custodial care also includes supervision of the patient for safety reasons. It also includes durable medical equipment that does not treat a condition, but is used to facilitate activities of daily living, such as but not limited to hoyer lifts, electric wheelchairs, bath chairs, and raised toilet seats.

DEEMED EXHAUSTED

Means a claimant can initiate an external review because the Plan failed to strictly adhere to the internal appeal procedure.

DENTAL

Any care or treatment or surgery relating to the teeth or gums, including but not limited to preventative dental care, extractions, restorations, endodontics, periodontics, prosthodontics, oral surgery for any condition which is caused by or related to a problem of the teeth, medications, or any appliances which rest upon or are attached to the teeth. For the purposes of this Plan, all care, surgery, or treatment of this type will be considered dental treatment or surgery, regardless of the origin of the condition which caused the treatment or surgery.

DEPENDENT

Means the Spouse and the Child or Children of the Employee, who are not themselves covered as Employees under this plan.

DURABLE MEDICAL EQUIPMENT

Durable medical equipment is medical equipment:

- Which is preauthorized as required by the Plan;
- Is used repeatedly;
- Serves a medical purpose;
- Would not be useful to a person without an injury or illness;
- Is appropriate for treating an illness or injury in the home; and
- Is the standard model equipment that meets the patient's needs.

It includes blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, lancets, and lancing devices.

The following items are not considered durable medical equipment, and are not covered under this plan:

- Air purifiers or cleaners, air conditioners, humidifiers, dehumidifiers, vaporizers, or heaters
- Any equipment which provides comfort or convenience
- Structure or vehicle alterations, ramps, or elevators
- Whirlpools, exercise machines of any type, swimming pools, hot tubs
- Computers or communication devices
- Heating pads, heat lamps, ice bags, or cold pack pumps
- Raised toilet seats, translift chairs, tub chairs used in a tub or shower
- Duplicate equipment
- Similar types of items or equipment, or
- Expense in excess of the cost for the standard model of equipment that is attributable to purchasing a more advanced model of equipment than what is covered under this plan.

EFFECTIVE DATE

The date coverage is put in force or the date the Participant is added to this Plan.

EMERGENCY CARE

Means covered expense for services for treatment of an injury or emergency medical condition that reasonably requires the Participant to seek immediate medical care under circumstances, or at locations which preclude the Participant from obtaining needed medical care from a Preferred Provider.

It does not mean covered expense for services provided by a Non-Preferred Provider once a referral can be made to safely transfer the patient to the care of a Preferred Provider.

EMERGENCY SERVICES

Means those medical and health services provided to treat a medical condition, manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- Serious impairment to bodily functions; or

- Serious dysfunction of any bodily organ or part.

Means with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as is required to stabilize the patient.

ENROLLMENT DATE

Means the earlier of the date of enrollment of the individual in the Plan, or the first day of the waiting period of enrollment.

EQUIVALENT GENERIC DRUG

Means a drug that the Pharmacy Benefit Manager has classified as safe, equivalent to, and as effective as the brand name drug that would otherwise have been prescribed.

EVALUATION AND MANAGEMENT SERVICES

Means those services properly assigned a CPT (American Medical Association Current Procedural Terminology) evaluation and management services code.

EXPERIMENTAL/INVESTIGATIONAL

Means any drug, biologic, device, diagnostic service, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation, or treatment of an injury or illness if one or more of the following criteria apply. The drug, biologic, device, diagnostic service, product, equipment, procedure, treatment, service or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use; or
- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or
- Is subject to review and approval of an Institutional Review Board or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

It also means any service, supply, or treatment that is not commonly and customarily recognized by the physician's profession and within the United States as appropriate treatment of the patient's diagnosed illness or injury and determined to be of proven effectiveness by the appropriate National Scientific Organization related to the diagnosed illness or injury.

It also means any procedures, drugs, or devices with unproven efficacy. Unproven efficacy means that the procedures, drugs, or devices have not been used with sufficient frequency or have not achieved the requisite success rates to establish their safety and efficacy in the medical community. A procedure, drug, or device may be considered experimental/investigational for certain diagnoses and conditions, and considered established therapies for other diagnoses and conditions.

A medical treatment, procedure, drug or device that is not considered an Approved Clinical Trial will be considered experimental or investigational if reliable evidence shows it is the subject of ongoing phase I II, or III clinical trials or under study to determine its safety, efficacy, or its efficacy as compared with the standard means of treatment or diagnosis, and reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis, and/or approval has not been given by the United States Food and Drug Administration at the time it is furnished.

The fact that a procedure, drug, or device is the only available treatment for a condition will not make it eligible for coverage if it is Experimental/Investigational according to this definition.

EXTERNAL REVIEW

Means a review of an adverse benefit determination, including a final internal adverse benefit determination, under applicable federal external review procedures.

FAMILY STATUS CHANGE

A marriage, a birth, an adoption, or a child being place for adoption.

FINAL EXTERNAL REVIEW DECISION

Means a determination by an independent review organization at the conclusion of an external review.

FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

Means:

- An adverse benefit determination that has been upheld at completion of the Internal Appeal Procedures; or
- An adverse benefit determination for which the internal appeals procedures have been exhausted under the "deemed exhausted" rule in the Appeals procedure.

This Plan provides for two levels of appeal. Completion of the second level appeal with an adverse benefit determination will result in a final internal adverse benefit determination, and will trigger the right to an external review.

HEALTH INSURANCE COVERAGE

Benefits consisting of medical care under any hospital or medical service Plan or certificate, hospital or medical service contract, or health maintenance organization contract offered by a health insurance issuer.

HOME HEALTH CARE

Care and treatment of a Participant under a plan of care established by his/her physician. The plan must be submitted to the Third Party Administrator in writing, and be preapproved. The plan of care must be reviewed at least every two months by your physician.

It consists of the medically necessary services for:

- Part-time or intermittent home nursing care by or under the supervision of a registered nurse (R.N.);
- Part-time or intermittent home health aide services, which solely consist of caring for the patient, and which are provided under the supervision of a R.N. or medical social worker;
- Physical, respiratory, occupational or speech therapy;
- Nutrition counseling provided by or under the supervision of a registered dietician;
- Evaluation and development of a home health plan by a R.N., physician extender or medical social worker, when approved or requested by the primary care physician.

The home health care services must be provided or coordinated by a state-licensed or Medicare-certified home health agency or rehabilitation agency.

Up to 4 consecutive hours of care will be considered one home health care visit.

HOSPICE

An agency that provides a coordinated program of home and inpatient care for the special physical, psychological, and social needs of terminally ill persons and their families. The hospice agency must:

- Be certified or licensed as a hospice by the state in which they are operating;
- Operate under the direct supervision of a physician;
- Provide services 24 hours a day, seven days a week; and
- Maintain medical records on each patient.

HOSPICE CARE

Care and treatment provided by a hospice for a terminally ill person and the immediate family members of the person if they are covered under this Plan.

HOSPITAL

Means a place which:

- Is legally operated for the inpatient care and treatment of ill or injured persons;
- Is mainly engaged in providing medical and diagnostic services;
- Has continuous 24 hour nursing services; and
- Has a staff of one or more physicians available at all times.

It does not mean:

- A rest, nursing, or convalescent home;
- A facility or institution mainly for the treatment of alcoholics or drug addicts;
- A facility primarily affording custodial or educational care for persons suffering from mental diseases or disorders; or
- A freestanding ambulatory surgical facility that arranges for overnight stays within the facility.

ILLNESS

Any condition, disease, or sickness which causes loss and affects normal bodily function, other than a condition caused by injury.

It also means:
- A pregnancy or complication of pregnancy;
- A congenital defect or birth abnormality for a child.

IMMEDIATE FAMILY

The Participant's spouse, children, parents, brothers and sisters.

INDEPENDENT REVIEW ORGANIZATION

Means an entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations.

INJURY

Bodily injury caused by an accident.

IN-NETWORK

Means covered expense provided by a Preferred Provider.

IN-NETWORK COINSURANCE SHARE

The amount of covered expense that a participant must pay for services provided by a Preferred Provider in a Calendar Year, after the Plan has paid the coinsurance amount. In-network Coinsurance share does not include:
- Any Deductible amounts
- Any Copay amounts
- Any amount the participant had to pay under the prescription medication benefit
- Any penalty for noncompliance with plan requirements
- Any Transplant amount
- Any out of network coinsurance share
- Any non-covered services

The Tier 1 and Tier 2 In-network coinsurance share amounts are shown on the Schedule of Benefits.

Expenses incurred by you for Covered Expenses rendered by a Tier 1 Preferred Provider which are applied towards the Tier 1 Coinsurance will be applied towards the Tier 2 Coinsurance.

Expenses incurred by you for Covered Expenses rendered by a Tier 2 Preferred Provider which are applied towards the Tier 2 Coinsurance will be applied towards the Tier 1 Coinsurance.

IN-NETWORK DEDUCTIBLE

The amount of covered expense for services provided by a Preferred Provider that must be incurred in a Calendar Year by a participant before any covered expense is paid by the Plan. It is equal to the lesser of:

- The amount specified under the In-Network Individual Deductible amount shown on the Schedule of Benefits
- The amount needed to satisfy the In-Network Family Deductible amount shown on the Schedule of Benefits

The Tier 1 and Tier 2 In-network Deductible amounts are shown on the Schedule of Benefits.

Expenses incurred by you for Covered Expenses rendered by a Tier 1 Preferred Provider which are applied towards the Tier 1 deductible will be applied towards the Tier 2 deductible.

Expenses incurred by you for Covered Expenses rendered by a Tier 2 Preferred Provider which are applied towards the Tier 2 deductible will be applied towards the Tier 1 deductible.

Out of Network Deductible and prescription Copay amounts will not be used to satisfy the In-Network deductible amount.

If you have any Covered Expenses in the last three months of a Benefit Period which were or could have been applied to that Benefit Period's deductible, these expenses may be applied towards the deductible for the next Benefit Period.

Out of Network Deductible, and prescription Copay amounts will not be used to satisfy the In-Network deductible amount.

IN-NETWORK FAMILY DEDUCTIBLE

The maximum amount of deductible a covered family must pay in a Calendar Year for services provided by Preferred Providers. This amount is shown on the Schedule of Benefits. The In-Network Family Deductible may be satisfied by combining all amounts applied to In-Network Individual Deductibles for covered Participants for the Calendar Year. No one Participant will be required to satisfy more than the applicable Individual In-Network Deductible. However, only covered expense that is incurred in a Calendar Year and applied to that same Calendar Year's In-Network Individual Deductible can be used to satisfy the In-Network Family Deductible.

The Tier 1 and Tier 2 In-network Deductible amounts are shown on the Schedule of Benefits.

IN-NETWORK INDIVIDUAL DEDUCTIBLE

The maximum amount of deductible that an individual participant must pay in a Calendar Year for services provided by Preferred Providers.

The Tier 1 and Tier 2 In-network Deductible amounts are shown on the Schedule of Benefits.

INPATIENT

Means a confinement in a hospital that results in the hospital making a room and board charge. An overnight stay in an observation unit of a hospital or licensed ambulatory surgical facility will be considered an inpatient stay for pre-certification purposes.

INTENSIVE CARE

Means a separate area in a hospital for the inpatient care of patients who are critically ill which:

- Provides constant nursing care which is not usual in other rooms and wards; and
- Has special lifesaving equipment which is immediately available at all times; and
- Has at least one R.N. on duty at all times.

LOSS OF ELIGIBILITY OF COVERAGE

Means a loss of coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment. It also means a loss of coverage under the COBRA continuation provision he/she was covered under because the period of time allowed for coverage under COBRA has been exhausted. It does not mean loss of coverage due to failure to timely pay required contributions or premiums or loss of coverage for cause, such as fraud or intentional misrepresentation.

MAIL ORDER PRESCRIPTION COPAY AMOUNT

The amount the participant must pay for each prescription order obtained through the mail service program.

MANIPULATIVE THERAPY

Treatment consisting primarily of manipulation, heat, ultrasound, diathermy or similar types of treatment, regardless of the medical degree of the person providing the treatment.

MAXIMUM ALLOWABLE AMOUNT

Means the cost of a procedure, drug, or device that would adequately accommodate treatment of a Participant's condition.

MEDICALLY NECESSARY

Means treatment that is or will be provided for the diagnosis, evaluation, and treatment of an illness or injury and that is:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the patient's illness or injury;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting, or level of service that can safely be provided to the patient, and which cannot be omitted consistent with recognized professional standards of care; for a hospitalization, it means that safe and adequate care could not be obtained in a less comprehensive setting or level of care;

- Cost-effective compared to alternative interventions, including no intervention;
- Not experimental/investigational; The fact that a service is the only available treatment for a condition will not make it eligible for coverage if it is Experimental/Investigational according to the definition in this Plan;
- Not primarily for the convenience of the patient, the patient's family, or the provider.

The fact that a provider may prescribe, order, recommend, or approve any care or treatment does not, of itself, make any care or treatment Medically Necessary or a covered expense and does not guarantee payment.

MEDICARE

Title XVIII of the Social Security Act as amended.

MEDICAID

Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act as amended.

MINOR

A person who is under the legal age of competence.

MORBID OBESITY

Morbid Obesity means:

(1) A body mass index of at least thirty-five (35) kilograms per meter squared, with co morbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or

(2) A body mass index of at least forty (40) kilograms per meter squared without co morbidity.

For purposes of this section, body mass index is equal to weight in kilograms divided by height in meters squared.

NEWBORN CHILD

A dependent child born to the employee while the employee is a Participant under this Plan.

NEW ENROLLEE

Means an eligible employee or dependent who applies for insurance within 30 days of his/her date of eligibility under this.

NEVER EVENT

Means any occurrence on a United States list of inexcusable outcomes in a health care setting compiled by the National Quality Forum. They are defined as "adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability."

NON-PREFERRED PROVIDER

Means any medical provider who has not entered into a written agreement with the Plan Administrator or the designated Preferred Provider Organization under contract with the Plan Administrator to provide services to the Plan Administrator's Participants at a negotiated rate. However, it does not mean a provider within 50 miles of the Participant's residence if the nearest Preferred Provider is more than 50 miles from the Participant's residence.

OUT OF POCKET MAXIMUM – In-Network

Any share of a covered expense the Participant is required to pay for In-Network covered expenses. This Maximum includes any In-Network Deductible, In-Network Coinsurance and copay amounts applied to covered services. Non-covered services and benefit reductions are not included in this Maximum.

The Tier 1 and Tier 2 In-network Deductible and Coinsurance amounts are shown on the Schedule of Benefits.

Expenses incurred by you for Covered Expenses rendered by a Tier 1 Preferred Provider which are applied towards the Tier 1 deductible will be applied towards the Tier 2 deductible.

Expenses incurred by you for Covered Expenses rendered by a Tier 2 Preferred Provider which are applied towards the Tier 2 deductible will be applied towards the Tier 1 deductible.

Out of Network Deductible and prescription Copay amounts will not be used to satisfy the In-Network deductible amount. All pharmacy and drug Copays and Coinsurance apply towards Tier 2 Out-of-Pocket Maximum.

If you have any Covered Expenses in the last three months of a Benefit Period which were or could have been applied to that Benefit Period's deductible, these expenses may be applied towards the deductible for the next Benefit Period.

OUT OF POCKET MAXIMUM – Out-of-Network

Any share of a covered expense the Participant is required to pay for Out-of-Network covered expenses. This Maximum includes any Out-Of-Network Deductible and Out-of-Network Coinsurance amounts applied to covered services. Copays/Access Fee, non-covered services and benefit reductions are not included in this Maximum.

OUT OF NETWORK

Means covered expense provided by a Non-Preferred Provider unless the Plan Administrator agrees to make an exception and designate the provider In-Network for a treatment episode, or a portion of a treatment episode, or a portion of a treatment episode. Plan Administrator's approval must be in writing.

OUT OF NETWORK COINSURANCE SHARE

The amount of covered expense that a participant must pay for services provided by a Non-Preferred Provider in a Calendar Year, after the Plan has paid the Out-of-Network Coinsurance amount. Out of network Coinsurance share does not include:

- Any deductible amounts
- Any amount the participant had to pay under the prescription medication benefit
- Any penalty for noncompliance with plan requirements
- Any Transplant Amount
- Any in-network coinsurance share
- Any non-covered services

The out of network coinsurance share amount is shown on the Schedule of Benefits.

OUT OF NETWORK DEDUCTIBLE

The amount of covered expense for services provided by a Non-Preferred Provider that must be incurred in a Calendar Year by a participant before any covered expense is paid by the Plan. It is equal to the lesser of:

- The amount specified under the Out of Network Individual Deductible amount shown on the Schedule of Benefits
- The amount needed to satisfy the Out of Network Family Deductible amount shown on the Schedule of Benefits.

In-Network Deductible and prescription Copay amounts will not be used to satisfy the Out of Network deductible amount.

OUT OF NETWORK FAMILY DEDUCTIBLE

The amount of deductible a covered family must pay in a Calendar Year for services provided by Non-Preferred Providers. This amount is shown on the Schedule of Benefits. The Out-of-Network Family Deductible may be satisfied by combining all amounts applied to Out of Network Individual Deductibles for covered Participants for the Calendar Year. No one Participant will be required to satisfy more than the applicable Individual Out-of-Network Deductible.

OUT OF NETWORK INDIVIDUAL DEDUCTIBLE

The maximum amount of deductible that an individual participant must pay in a Calendar Year for services provided by Non-Preferred Providers.

PARTICIPANT

Means any employee or employee's dependent who is covered for benefits under this Plan.

PHYSICIAN

Means a practitioner of the healing arts, licensed by the state he/she practices in. He/she must be performing only those services he/she is licensed to perform.

POST-SERVICE CLAIM

Means any claim for benefit under this Plan that is not a pre-service claim or an urgent care claim.

PRE-AUTHORIZED USE OF A NON-PREFERRED PROVIDER

Authorization obtained for non-emergency care prior to treatment by a Non-Preferred Provider.

PREFERRED PROVIDER

Means a Tier 1 In-Network Provider or a Tier 2 In-Network Provider who has entered into a written agreement to provide services to the Plan Participants at a negotiated rate. The Schedule of Benefits indicates the name of the network of providers contracted with the Plan. The Plan recommends that you verify that the provider You are using or considering is currently a Preferred Provider.

- **Tier 1 In-Network Provider** means a Provider which has a written agreement *with the PHN Network to provide covered services to You at the time services are rendered to* You. If Hospital services are **not** available at Pekin Hospital and You receive those services at UnityPoint Methodist/Proctor those services will be subject to the Tier 1 deductible, coinsurance and Out of Pocket Maximum. If care by a specialist is medically necessary and appropriate, and there is no Preferred Provider of the required specialty in the Tier 1 Network (PHN), the Plan will consider covered health expenses by a Tier 2 Network (First Choice) Provider to be considered as if services were provided by a Tier 1 Network Preferred Provider. If there is no Tier 1 or Tier 2 Network Preferred Provider of the required specialty within a 50 mile radius, the Plan will consider covered health expenses by the Out-of-Network provider to be considered as if services were provided by a Tier 2 Network Preferred Provider. All pharmacy and drug Copays and Coinsurance apply towards Tier 2 Out-of-Pocket Maximum.

- **Tier 2 In-Network Provider** means a medical provider who has entered into a written agreement to provide services to the Plan Participants at a negotiated rate through the Tier 2 Network. The Schedule of Benefits indicates the name of the network of providers contracted with the Plan. If Hospital services are **not** available at Pekin Hospital and You receive those services at UnityPoint Methodist/Proctor those services will be subject to the Tier 1 deductible, coinsurance and Out of Pocket Maximum. If care by a specialist is medically necessary and appropriate, and there is no Preferred Provider of the required specialty in the Tier 1 Network (PHN), the Plan will consider covered health expenses by a Tier 2 Network (First Choice) Provider to be considered as if services were provided by a Tier 1 Network Preferred Provider. If there is no Tier 1 or Tier 2 Network Preferred Provider of the required specialty within a 50 mile radius, the Plan will consider covered health expenses by the Out-of-Network provider to be considered as if services were provided by a Tier 2 Network Preferred Provider. All pharmacy and drug Copays and Coinsurance apply towards Tier 2 Out-of-Pocket Maximum.

  It also means a provider who is a member of the Preferred Provider travel network listed on the back of the Participant member's identification card, if the treatment being provided is for an unexpected illness or injury while traveling outside the Participant's primary PPO service delivery area or if a Spouse or Dependent lives outside the Participant's primary PPO service delivery area.

It also means a provider who is a member of the Preferred Provider travel network listed on the back of the Participant member's identification card, if the treatment being provided is for an unexpected illness or injury while traveling outside the Participant's primary PPO service delivery area.

PRESCRIPTION COPAY

The amount the participant must pay for each prescription order obtained at a retail pharmacy. It is shown on the Schedule of Benefits.

PRE-SERVICE CLAIM

Means a claim for benefits under the Plan for services that are not covered under the Plan unless approval in advance is obtained.

PRE-SERVICE URGENT CARE CLAIM

Any pre-service claim for medical care or treatment where, in the opinion of a physician with knowledge of the claimant's medical condition, a delay in determining if the service is approved under the Plan could seriously jeopardize the claimant's life or health, or ability to regain maximum function.

Upon receipt of a pre-service claim, the Plan Administrator will make a determination if it is a Pre-service Urgent Care Claim. However, if a physician with knowledge of the claimant's medical condition determines that the claim is a Pre-service Urgent Care Claim, the Plan will treat the claim as a Pre-service Urgent Care Claim.

PROOF OF INCAPACITY

Medical proof that a dependent child is incapable of self-support, and solely dependent on the Participant for maintenance and support due to mental retardation or physical handicap.

PROOF OF LOSS

Consists of:

- A properly completed claim form; and
- Any other information the Plan needs to process the claim.

PROVIDER

Means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render covered services to You.

- An **"In-Network Provider Tier 1 - PHN"** means a Provider which has a written agreement with the PHN Network to provide covered services to you at the time services are rendered to You. If Hospital services are **not** available at Pekin Hospital and You receive those services at UnityPoint Methodist/Proctor those services will be subject to the Tier 1 deductible, coinsurance and Out of Pocket Maximum. If care by a specialist is medically necessary and appropriate, and there is no Preferred Provider of the required specialty in the Tier 1 Network (PHN), the Plan will consider

covered health expenses by a Tier 2 Network (First Choice) Provider to be considered as if services were provided by a Tier 1 Network Preferred Provider. If there is no Tier 1 or Tier 2 Network Preferred Provider of the required specialty within a 50 mile radius, the Plan will consider covered health expenses by the Out-of-Network provider to be considered as if services were provided by a Tier 2 Network Preferred Provider. All pharmacy and drug Copays and Coinsurance apply towards Tier 2 Out-of-Pocket Maximum.

- An **"In-Network Provider - Tier 2"** means a medical provider who has entered into a written agreement to provide services to the Plan Participants at a negotiated rate through the Tier 2 Network. The Schedule of Benefits indicates the name of the network of providers contracted with the Plan. The Plan recommends that you verify that the provider you are using or considering is currently a Preferred Provider. If Hospital services are **not** available at Pekin Hospital and You receive those services at UnityPoint Methodist/Proctor those services will be subject to the Tier 1 deductible, coinsurance and Out of Pocket Maximum. If care by a specialist is medically necessary and appropriate, and there is no Preferred Provider of the required specialty in the Tier 1 Network (PHN), the Plan will consider covered health expenses by a Tier 2 Network (First Choice) Provider to be considered as if services were provided by a Tier 1 Network Preferred Provider. If there is no Tier 1 or Tier 2 Network Preferred Provider of the required specialty within a 50 mile radius, the Plan will consider covered health expenses by the Out-of-Network provider to be considered as if services were provided by a Tier 2 Network Preferred Provider. All pharmacy and drug Copays and Coinsurance apply towards Tier 2 Out-of-Pocket Maximum.

  It also means a provider who is a member of the Preferred Provider travel network listed on the back of the Participant member's identification card, if the treatment being provided is for an unexpected illness or injury while traveling outside the Participant's primary PPO service delivery area or if a Spouse or Dependent lives outside the Participant's primary PPO service delivery area.

- An **"Out-of-Network Provider"** means any medical provider who has not entered into a written agreement with the designated Preferred Provider Organization under contract with the Plan Administrator to provide services to the Plan Administrator's Participants at a negotiated rate. Out-of-Network Out of Pocket Maximum applies.

REGULAR, REASONABLE & CUSTOMARY

It is the lesser of:

- the actual charge;
- what the provider will accept for the same service or supply in the absence of insurance;
- the amount the provider has agreed to charge under a Preferred Provider agreement with the Plan;
- the amount the provider has agreed to accept under the terms of a negotiated agreement with the Plan;

- an amount determined by the Plan by comparing charges made by other medical professionals and/or facilities with similar credentials, for similar services and supplies, adjusted to the geographic locale, and based upon the Regular, Reasonable & Customary percentile level deemed appropriate by the Plan;
- an amount based on the level and/or method of reimbursement used by the Centers of Medicare and Medicaid Services for the same services or supplies; or
- an amount based on accepted industry standard or a commercially available database using factors such as, but not limited to the:
    - complexity or severity of the treatment;
    - level of skill and experience required for the treatment;
    - cost and quality data;
    - comparable fees and costs for the treatment;
    - reimbursement amounts paid by Centers for Medicare and Medicaid Services for the same services or supplies;
    - generally accepted billing practices; and/or
    - industry standard cost, reimbursement, and utilization data.

Regular, Reasonable & Customary for certain surgical charges will be determined as follows:

- for multiple surgical procedures performed at the same operative session, the Plan will allow up to 100% of the Regular, Reasonable & Customary amount for the first surgical procedure, 50% of the Regular, Reasonable & Customary amount for the second surgical procedure, and 25% of the Regular, Reasonable and Customary amount for each additional surgical procedure;
- for charges by an assistant surgeon, the Plan will allow up to 20% of the amount allowed for the primary surgical procedure when an assistant is deemed Medically Necessary.

The Plan Administrator reserves the right to take into consideration all of the above means of determining the Regular, Reasonable & Customary rate and in some instances an allowable amount may not be the lesser of.

RESIDENTIAL TREATMENT CENTER

A facility, licensed as such under applicable law, whose primary function is offering therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision and structure. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Health Conditions, Serious Mental Health Conditions and/or Substance Use Disorders.

SCHEDULE OF BENEFITS

A list which states those benefits that the Plan Administrator has decided to provide to participants.

SKILLED NURSING FACILITY

Means a legally operated institution or a part of an institution for the treatment of inpatients. Treatment must be under the supervision of a Physician. The facility must provide 24 hour nursing service under the supervision of a R.N. It must maintain daily medical records of each patient. This definition does not include:

- a rest home or home for the elderly;
- an institution, nor a unit of an institution, used for custodial or educational care;
- an institution, nor a unit of an institution, used for the treatment of alcoholics, drug addicts, or the mentally ill.

SPOUSE

Means a party to a legal marriage or Civil Union.

STABILIZE

Means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

Means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TERMINALLY ILL PERSON

A person who has been diagnosed by a physician as having a life expectancy of six months or less.

TOTAL DISABILITY

Total Disability shall mean an individual is determined as being disabled for Social Security purposes and provides such evidence to the Plan of the determination as the Plan Administrator may, in its sole discretion, require.

TRANSPLANT CENTER OF EXCELLENCE

Means a facility which has entered into an agreement through a national organ transplant network to render approved transplant services to the Plan's Participants. The transplant center of excellence facility may or may not be located within the Participant's geographic area. A list of transplant center of excellence facilities upon request will be made available to the participants.

URGENT CARE CLAIM

Any pre-service claim for medical care or treatment where, in the opinion of a physician with knowledge of the claimant's medical condition, a delay in determining if the service is approved under the Plan could seriously jeopardize the claimant's life or health, or ability to regain maximum function.

Upon receipt of a pre-service claim, the Plan Administrator will make a determination if it is an urgent care claim. However, if a physician with knowledge of the claimant's medical condition determines that the claim is an urgent care claim, the Plan will treat the claim as an urgent care claim.

YOU, YOUR

Means a Plan Participant.

ELIGIBILITY AND EFFECTIVE DATE FOR COVERAGE

Eligibility for Employee Coverage

All Active Full-time Employees of PEKIN PARK DISTRICT are eligible to become covered under the Plan as of the date of their Active Full-Time Employment.

Effective Date for Employee Coverage

An eligible employee will become covered under the Plan on the date he/she becomes an Active Full-time Employee at PEKIN PARK DISTRICT if he/she submits an enrollment form within 30 days of the date he is eligible to become covered under this Plan.

Eligibility for Dependent Coverage

An Employee's Dependents are eligible to be covered under this Plan on the earliest of the following dates:

- The date the employee becomes covered under this Plan;
- The first date the employee has an eligible dependent.

The employee must enroll any eligible dependents within 30 days of the date they are first eligible for them to become covered as a dependent under the Plan.

A person cannot be covered as both a dependent and an employee under the Plan. A dependent child cannot be covered as a dependent of more than one Employee who is covered under the Plan.

Newborn Children

A newborn child is covered from the moment of birth. In order for coverage to extend beyond the first 30 days after birth, you must submit an enrollment form for the newborn within 30 days after the newborn's birth.

A well newborn's initial hospital confinement will only be considered covered expense if we are paying benefits for the mother's pregnancy under this benefit.

Special Enrollment Periods

For Persons Who Previously Declined Coverage

A person who previously declined coverage in writing because they were covered under another group health plan or health insurance coverage may have a 30 day special enrollment period if they lose that coverage.

The 30 day special enrollment period will begin for that person on the day the person experiences a loss of eligibility for coverage. The person must submit a special enrollment form during that time to become covered by the Plan.

Coverage will become effective on the first of the month following the date the person applies.

Due to a Change in Family Status

A person will have a 30 day special enrollment period to apply for coverage beginning on the date a family status change occurs. The person must submit a special enrollment form during that time to become covered by the Plan.

In the case of a family status change due to marriage, coverage will begin on the first day of the month, after the special enrollment form is received, as long as enrollment occurs within the 30 day special enrollment period.

In the case of a family status change due to the birth of a dependent child, coverage will begin on the child's date of birth, after the special enrollment form is received, as long as enrollment occurs within the 30 day special enrollment period.

In the case of a family status change due to adoption or placement for adoption, coverage will begin on the date of the adoption or placement for adoption, after the special enrollment form is received, as long as enrollment occurs within the 30 day special enrollment period.

Qualified Medical Child Support Order

The plan administrator will enroll for immediate coverage under this Plan any alternate recipient who is the subject of a Medical Child Support Order that is a Qualified Medical Child Support Order ("QMCSO") if such an individual is not already covered by the Plan as an eligible dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

Alternate Recipient means any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible dependent.

Medical Child Support Order means any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

- Provides for child support with respect to a Participant's child or directs the participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
- Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a

group health plan.

National Medical Support Notice or "NMSN" means a notice that contains the following information:

- Name of an issuing State agency
- Name and mailing address (if any) of an employee who is a Participant under the Plan
- Name and mailing address of one or more alternate recipients, and
- Identity of an underlying child support order.

Qualified Medical Child Support Order or "QMCSO" is a medical child support order that creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Participant or eligible dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

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

In addition, a NMSM shall be deemed a QMCSO if it:

- Contains the information outlined in the definition of National Medical Support Notice
- Identifies either the specific type of coverage or all available group health coverage. If the employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and Plan Administrator will assume that all are designated
- Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any)
- Specifies that the period of coverage may end for the alternate recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as qualified if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible plan participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to medical child support orders, as described in Social Security Act §1098 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

- Notify the Participant and each alternate recipient covered by the Order in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO, and
- Make an administrative determination if the order is a QMCSO and notify the Participant and each alternate recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

- Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
    - Whether the child is covered under the Plan, and
    - Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to

effectuate the coverage, and
- Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:
- Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice, and
- Permit any alternate recipient to designate a representative for receipt of copies of the notices that are sent to the alternate recipient with respect to the Order.

Additional Special Enrollment Rights
Employees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances;
- The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan with (60 days) after the termination; or
- The Employee or Dependent become eligible for a contribution/premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests Plan coverage within 60 days after eligibility is determined.

Open Enrollment
Once annually Employees will have a choice of enrolling in this Plan. Employees will be notified in advance when the open enrollment period is to begin and how long it will last. If Employee declined coverage at the time they were initially eligible for coverage, the Employee will be able to enroll during the open enrollment period. Coverage elected during the open enrollment period will become effective the first day of the Plan Year immediately following the open enrollment period.

TERMINATION OF COVERAGE

Termination Dates of Employee Coverage
The coverage of any Employee under this Plan will end on the earliest of the following dates:
- the date this entire Plan terminates;
- the last day of the month coinciding with or immediately following the date he/she requests coverage be terminated, as long as the request is made on or before the date requested;
- the last day of the period for which the Employee has made a contribution, if he/she fails to make a required contribution for coverage when it is due;
- the last day of the month coinciding with or immediately following the date he/she ceases to be eligible for coverage under the Plan;
- the last day of the month coinciding with or immediately following the date his/her employment is terminated; or
- immediately after an Employee or his/her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under this Plan will end on the earliest of the following dates:
- the date this entire Plan terminates;
- the date coverage for Dependents is discontinued under this Plan;

- the date the Employee's coverage under this Plan ends;
- the last day of the period for which the Employee has made a contribution, if he/she fails to make a required contribution for Dependent coverage when it is due;
- In the case of a child age 26 or older, for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest of the last day of the month coinciding with or immediately following:
    - The date of cessation of such inability;
    - The date proof of the uninterrupted continuance of such inability is not provided, including failure to submit to any requested examination;
    - The date the child is no longer dependent on the Employee for his or her support;
- the last day of the month coinciding with or immediately following the date such person ceases to be a Dependent as defined in this Plan, except as may be provided for in other areas of this section; or
- Immediately after an Employee or his/her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Employer Continuation Coverage

As long as contributions by the Employee continue, coverage will be continued for eligible Participants in the event of an approved leave of absence which does not meet the requirements of FMLA leave, coverage will continue for up to 6 months.

Continuation During Family and Medical Leave

In accordance with the Family and Medical Leave Act of 1993 ("FMLA"), continuation coverage under the Plan is available to Participants under certain specified conditions.

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

- Coverage shall cease for a Covered Employee (and his covered dependents) for the duration of the leave if at any time the Covered Employee is more than 30 days late in paying any required contribution.
- A covered employee 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.
- If a covered employee 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 employee advises the employer that he does not desire restoration to employment at the end of the leave period, or the leave entitlement is exhausted, or reinstatement is actually denied.
- Any portion of the cost of coverage which had been paid by the covered employee prior to the leave must continue to be paid by the covered employee during the leave. If the cost is raised or lowered during the leave, the covered employee shall pay the new rates. If the leave is unpaid, the covered employee and the employer shall negotiate a reasonable means for paying the covered employee's portion of the cost.
- If the employer provides a new health plan or benefits or changes the health benefits or Plan while the covered employee is on leave, the covered employee is entitled to the new or changed Plan and benefits to the same extent as if the covered employee

were not on leave.

- The employer may recover its share of the cost of benefits paid during a period of unpaid leave if the covered employee fails to return to work after the covered employee's leave entitlement has been exhausted or expires, unless the reason the covered employee does not return to work is due to:
    - The continuation, recurrence, or onset of a serious health condition which would entitle the covered employee to additional leave under the FMLA, or
    - Other circumstances beyond the covered employee's control.

If a covered employee 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 employee's behalf during a period of unpaid leave, the employer may require medical certification of the covered employee's or the covered dependent's serious health condition. The covered employee is required to provide medical certification within thirty days from the date of the employer's request. If the employer requests medical certification and the covered employee does not provide such certification in a timely manner, the employer may recover the costs of benefits paid during the period of unpaid leave.

Employees on Military Leave

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights apply only to employees and their dependents covered under the Plan before leaving for military service.

- The maximum period of coverage of a person under such an election shall be the lesser of:
    - The 24 month period beginning on the date on which the person's military leave begins, or
    - The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.
- A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the employee's share, if any, for the coverage.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not be terminated because of service. However, an exclusion may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

Illinois Municipal Retirement Fund ("IMRF") Benefits

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

- 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;

- The Dependents of such Participant who is 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

- The surviving spouse of such a retired or disabled Employee, but only if

the spouse:

(1) is covered under the Plan on the day before such Employee's 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 Participant 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.

AMOUNT OF BENEFIT FOR COVERED HEALTH EXPENSES

Preventative Care

The Plan will pay 100% of the regular, reasonable, and customary charge for covered expense incurred for preventive services, but only when provided by a Preferred Provider. The deductible will not apply to this benefit. Preventative services provided by Out-of-Network Providers covered as outlined on the Schedule of Benefits.

Preventive Services means:

- Items or services with a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force including those regarding breast cancer screening, mammography, and prevention, other than those issued on or around November 2009.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for the person receiving the immunization. Also flu immunizations received at retail pharmacies or health departments will be covered as if provided by a Preferred Provider.
- Preventive care and screenings provided for in the comprehensive guidelines supported by the health Resources and Services Administration for infants, children, and adolescents
- Preventive care and screenings for women as provided for by the Health Resources and Services Administration
- It includes:
    - Colorectal cancer examination and screening as recommended by the American Cancer Society
    - Shingles vaccine for Participants 60 years of age or older
    - Human papilloma virus vaccines
    - Screening mammography and clinical breast exams
    - Pap test for cervical cancer
    - Digital rectal examination and a prostate-specific antigen test
    - CA-125 serum tumor marker testing, transvaginal ultrasound and pelvic examination for Participants having a family history of one or more first-degree relatives with ovarian cancer, or with clusters of women relatives with breast cancer, or a family history of nonpolyposis colorectal cancer, or a positive BRCA1 or BRCA2 mutation test.
    - Any other preventative care as outlined on the Schedule of Benefits

It does not mean similar services when prescribed to monitor or diagnose a Participant who is having current symptoms or who has been diagnosed with an illness.

Benefit for Covered Health Expense by a Preferred Provider (PPO)

The Plan will pay according to the schedule of benefits for the covered expense provided by a Preferred Provider.

After the office visit Copay, the plan will pay 100% of covered expenses for the office visit (evaluation and management services only) charge made by a Preferred Provider for treatment of an illness or injury. The office visit Copay amount is shown on the Schedule of Benefits. It applies to each office visit (Evaluation and Management) charge by a Preferred Provider.

Before payment of any benefit for services by a Preferred Provider, other than the office visit (Evaluation & Management charge only), will be considered, covered expenses for these services must equal the applicable Tier 1 or Tier 2 In-Network Deductible during a calendar year. After meeting the calendar year In-Network Deductible the Plan will pay benefits for covered expenses provided by the Preferred Provider at the applicable Tier 1 or Tier 2 In-Network Coinsurance percentage as outlined on the Schedule of Benefits. If the amount of covered expense paid by the Participant for Tier 1 or Tier 2 Out of Pocket Maximum during a calendar year equals the applicable Tier 1 or Tier 2 In Network Out of Pocket Maximum, the plan will pay the covered expenses for those services at 100% for the remainder of the calendar year subject to any limitations outlined in the Plan or Schedule of Benefits.

Benefit for Covered Health Expense for Emergency Services Provided in a Hospital Emergency Room

When you incur covered expense for emergency services provided in a hospital emergency room, you must pay an Emergency Room Copay (refer to Schedule of Benefits). This amount must be paid anytime you receive Emergency Services in a hospital emergency room, and are not directly admitted to the hospital as an inpatient. If it is determined that Emergency Services were required, You will be charged the Emergency Room Copay amount designated on the Schedule of Benefits and additional Emergency Room Covered Expenses will be covered at 100% after the copay.

If you are directly admitted to the hospital as an inpatient following an emergency room visit, the Emergency Room Copay will be waived and the emergency room Covered Expenses will be covered at 100%. Covered Expenses incurred after you are admitted to the hospital from the emergency room will not be subject to deductible but the applicable coinsurance listed on the Schedule of Benefits will apply to those expenses.

If it is determined that Emergency Room Services were for a Non-Emergent situation, You will be charged the Emergency Room Copay amount designated on the Schedule of Benefits and the applicable Tier 1, Tier 2 or Out Of Network Deductible, Coinsurance percentages and Out-of-Pocket Maximum amounts as listed on the Schedule of Benefits will apply to all services received.

Benefit for Covered Health Expenses Provided by a Non-Preferred Provider

Before the Plan pays any benefits for services by a Non-Preferred Provider, covered health expenses equal to the Out-of-Network Deductible must be incurred in a Calendar Year. The Plan will then pay benefits for covered expenses provided by the Non-Preferred Provider that are in excess of the Out-of-Network Deductible for the remainder of the Calendar Year. These benefits will be paid at the Out-of-Network Coinsurance percentage shown on the Schedule of Benefits. If the amount of covered expenses the participant pays for Out-of-Network Deductible and Coinsurance during a Calendar Year equals the Out of Pocket Maximum - Out-of- Network, the plan will then pay covered health expenses for these services at 100% for the remainder of the Calendar Year.

Use of Non-Preferred Providers

When you use a Non-Preferred Provider:

- The amount of payment is based upon a reduced allowable amount, and not the actual billed charge; and
- You may be expected to pay a larger portion of the bill, even after the Plan has paid the percentage of eligible expense provided under the Plan.

Benefit for Emergency Services Provided by a Non-Preferred Provider

Emergency Services provided by a Non-Preferred Provider will be considered to be services from a Preferred Provider. If the Emergency Room visit is Non-Emergent then the applicable Out of Network benefits will apply as listed on the Schedule of Benefits.

Benefit for Specialty Physician Services by a Non-Preferred Provider

If care by a specialist is medically necessary and appropriate, and there is no Preferred Provider of the required specialty in the Tier 1 Network (PHN), the Plan will consider covered health expenses by a Tier 2 Network (First Choice) Provider to be considered as if services were provided by a Tier 1 Network Preferred Provider. If there is no Tier 1 or Tier 2 Network Preferred Provider of the required specialty within a 50 mile radius, the Plan will consider covered health expenses by the Out-of-Network provider to be considered as if services were provided by a Tier 2 Network Preferred Provider.

Use of Out-of-Network specialty physicians due to convenience, physician preference or patient/family preference do not qualify for extension of In-Network coverage. All covered health expenses from other providers resulting from use of a Specialty Provider will be considered Out-of-Network unless there are no In-Network providers available for use within a 50 mile radius.

Benefit for Self-Injected Medications Other Than Insulin

The Plan will consider covered self- injected medications, other than insulin and except for items excluded under Expenses Not Covered By The Plan. Participant must meet any

applicable Copay and deductible before covered self- injected medications will be considered. Self-Injected Medication must be for treatment of a Covered Health Expenses and must be approved by the Plan's case management. It must be purchased from the provider case management makes arrangements with. Insulin is only considered under the Prescription Medication Benefit. Self-Injected Medications must be for treatment of a Covered Health Expenses.

COVERED HEALTH EXPENSES UNDER THIS PLAN

Benefits are payable for covered expense.

Covered Expense means the medically necessary, regular, reasonable, and customary charges for medical services and supplies that are incurred:

- By a Participant while this Plan is in force; and
- Before coverage ends; and
- For the treatment of an illness or injury.

In determining whether an expense is a covered expense under this Plan, The Plan may take into consideration:

- The definitions, provisions, limitations, and exclusions in the plan, including the Schedule of Benefits, attachments and amendments;
- Any clinical coverage guidelines or medical policy as posted for The Plan on the Third Party Administrator's website;
- Medical peer reviews and recommendations provided by nationally recognized public and private organizations that review the medical effectiveness of health care services and technology.
- If proper pre-authorization or pre-certification has occurred as outlined in the Plan or Schedule of Benefits

Covered expenses are charges:

- By a hospital for:
    - Semiprivate room and board
    - Care in the Intensive Care Unit
    - Hospital services and supplies which are to be used while in the hospital
    - Emergency services in a hospital emergency room
    - Outpatient medical care and treatment
- For outpatient surgery performed in a licensed ambulatory surgical facility
- By a physician for:
    - Office visits
    - Hospital care
    - Surgical services, including postoperative care following inpatient or outpatient surgery
    - Services of an assistant surgeon when medically necessary to perform the surgery covered at 20% of the primary provider's allowable fee.
    - Injections and medication that must be consumed at the physician's office
    - Professional pathology laboratory services which are required to physically analyze a specimen and make a diagnosis, and for laboratory tests which do

not require the physician to make a personal interpretation as in the case of automated clinical pathology tests.

- For other services and supplies for:
    - Anesthesia and its administration
    - X-rays and radiation therapy
    - Chemotherapy, or similar treatment, provided in the office, hospital, or the home, but the covered expense for chemotherapy provided through a hospital or physician's office will not exceed the regular, reasonable, and customary fees for home chemotherapy
    - Laboratory tests
    - Blood, blood plasma, and its administration
    - Ostomy supplies
    - Allergens dispensed by a physician
    - Durable medical equipment for the purchase or rental when preauthorization has been approved as required by the Plan
    - Diabetes self –management training and supplies to test and monitor diabetes;
    - Test strips for glucose monitors
    - Self-injected medications, except insulin, when pre-approved by the Plan's case management, as required by the plan and outlined in the Schedule of Benefits except for items excluded under Expenses Not Covered By The Plan
    - One breast prosthesis per breast or reconstructive surgery following a mastectomy, including surgery and reconstruction of the other breast to produce a symmetrical appearance; replacement breast prosthesis once every two years; three post-mastectomy surgical bras every six months, limited to the standard model
    - For treatment of physical complications of a mastectomy, including lymphedema
    - Initial purchase of artificial eyes and larynx
    - Casts, trusses, crutches, orthotics, and splints. Orthotics must be custom made or custom fitted, made of rigid or semi-rigid material. Unless specifically stated otherwise, fabric supports, replacement orthotics and braces.
    - Orthopedic Braces when pre-approved, as required by the Plan except for items excluded under Expenses Not Covered By The Plan
    - The standard prosthetic limb that meets your needs as determined by the Plan; Initial purchase, fitting and adjusting of the limb; repair, refitting and/or replacement of a prosthetic limb as long as it has been properly maintained and not subjected to abuse or misuse, and when not covered by product warranty
    - The purchase of one pair of the following while insured:
        - One pair of orthopedic shoes;
        - One support stocking for each leg;
        - One article of similar apparel- type item;
- For home health care visits not to exceed:
    - The number of visits shown on the Schedule of Benefits during one Calendar Year, and
    - The cost for such care in an inpatient facility

- For care in a licensed skilled nursing facility when pre-approved, as required by the Plan, but not for longer than the number of days shown on the Schedule of Benefits during one Calendar Year
- For hospice care when preapproved, as required by the Plan
- For expense incurred for outpatient physical therapy, outpatient occupational therapy and only when the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time when preapproved, as shown on the Schedule of Benefits and as required by the Plan.
- For expense incurred for outpatient speech therapy by a licensed or certified speech therapist to restore speech loss or correct impairment due to a congenital defect for which corrective surgery has been performed, or an injury or illness except for a mental, nervous or emotional disorder will be considered covered expense when preapproved, as shown on the Schedule of Benefits and as required by the Plan.
- For expense incurred for inpatient stay in an inpatient rehabilitation facility, but only when the patient is able to participate in intensive therapy and treatment of at least 3 hours per day, and there is documented measureable improvement occurring as a result of the therapy, treatment, and stay
- For expense incurred for visits for outpatient cardiac rehabilitation, but only when the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time
- For expense incurred for visits for outpatient pulmonary rehabilitation, but only when the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time
- For expense incurred for chiropractic treatment and/or manipulative therapy subject to limits on the Schedule of Benefits.
- For expense incurred for acupuncture or acupressure treatment
- Medically necessary local ground ambulance transportation to the nearest Preferred Provider hospital able to provide the care
- Medically necessary air ambulance transportation to the nearest Preferred Provider hospital able to provide the care
- Injections for contraceptive purposes, including Depo-Provera and Norplant
- Contraceptive devices which require a written prescription before dispensing;
- elective sterilization surgery
- Medically necessary expense incurred for pregnancy
- Medically necessary expense incurred for a well or ill newborn, but only if dependent coverage has been added for the newborn within 30 days following the newborn's birth.
- Medically necessary expense incurred for the diagnosis and treatment of all mental illnesses, psychiatric conditions, and alcoholism and substance abuse, including:
    - Medically necessary individual outpatient mental health or rehabilitation care visits to qualified physicians, licensed clinical psychologists or clinical social workers as may be necessary and appropriate for evaluation, short-term treatment and crisis intervention services
    - Medically necessary inpatient mental health or rehabilitation care at an inpatient facility or hospital when preapproved, as required by the Plan
    - Inpatient Treatment at a Residential Treatment Center (Substance Use Disorders only)
    - Diagnosis, detoxification and treatment of the medical complications of the abuse of or addiction to alcohol or drugs on either an inpatient or outpatient basis, when preapproved, as required by the Plan
- Medically necessary expense incurred for an organ or bone marrow transplant, but only when performed at a facility designated as a transplant Center of Excellence facility, as required by the Plan.

- For clinical trials covered expenses includes routine patient costs incurred by a qualified individual who participates in an Approved Clinical Trial. A qualified individual who wishes to participate in an Approved Clinical Trial must obtain Case Management Prior Authorization and use an In-Network Provider if an In-Network Provider is participating in the trial and the In-Network Provider accepts the qualified individual as a participant in the trial. However, if the Approved Clinical Trial is either conducted outside the state in which the qualified individual resides by an Out-of-Network Provider or there is no In-Network provider conducting the Approved Clinical Trial and accepting the qualified individual in the individual's state of residence, then routine patient costs will be covered as if provided by an In-Network Provider and subject to Regular, Reasonable & Customary.
- For treatment of a pervasive developmental disorder that is prescribed by the Participant's treating physician in accordance with a treatment plan. All deductibles and maximum dollar limits apply to this treatment. Other exclusions or limitations do not apply to this treatment.
- Breast reduction surgery when performed in conjunction with reconstructive surgery following a mastectomy or where the Plan determines them to be medically necessary
- Non-experimental, medically necessary surgical treatment of morbid obesity when;
    - Morbid obesity has persisted for a t least five (5) years; and
    - For which nonsurgical treatment that is supervised by a physician has been unsuccessful for at least six (6) consecutive months; and
    - The participant is over the age of 21. Unless the participant is under 21 and
    - two (2) authorized physicians determine that the surgery is necessary to:
        - Save the life of the Participant; or
        - Restore the Participant's ability to maintain a major life activity

Each physician must document in the Participant's medical record the reason for the physician's determination.

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection.

Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one year requirement will be waived if your Physician determines a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

Benefits for treatments that include oocyte retrievals will be provided only when:

- You have been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that makes such treatment useless; and
- You have not undergone four completed oocyte retrievals, except that if a live birth followed completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to you. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.

The maximum number of completed oocyte retrievals that are eligible for coverage under this Plan in your lifetime is six. Following the final completed oocyte retrieval, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you. Thereafter, you will have no benefits for infertility treatment.

Special Limitations

Benefits will not be provided for the following:

1. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate.

2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.

3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance

4. Non-medical costs of an egg or sperm donor.

5. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by the Claim Administrator.

6. Infertility treatments which are deemed Investigational, in writing, by
the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.

7. Infertility treatment rendered to your dependents under age 18.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.

TRANSPLANT BENEFIT

The Plan will pay for covered expense for pre-authorized organ transplants according to the following schedule:

Center of Excellence Facility

100% of Approved Transplant Services

Coverage as outlined in Travel/Lodging Benefit

Organ Procurement and acquisition covered in full.

Non - Center of Excellence Facility

90% of the Covered Expense in excess of the Out of Network deductible for hospital charges, physician charges, tissue typing and other ancillary services related to the organ transplant. Once the Participant has paid 10% of $100,000 of covered expense for the transplant services listed above, then the Plan will pay 100% of the covered expense for those services for the rest of the Calendar Year during which the organ transplant occurred.

No coverage for transportation and lodging.

No coverage for organ procurement and acquisition.

Travel/Lodging Benefit

When a covered organ transplant is performed at a Center of Excellence Facility, the Plan will provide:

Transportation for the Participant patient and one member of the Participant patient's immediate family to accompany the Participant patient to and from the Designated Transplant Facility; and

Lodging at or near the Designated Transplant Facility for the family member who accompanied the Participant patient, while the covered person is confined at the Designated Transplant Facility.

The Plan will arrange the transportation and lodging at no cost to the Participant patient; except that the daily maximum benefit the Plan will pay for food and lodging for the family member who accompanied the covered person is $200.00 with a total maximum of $10,000. The Plan Administrator must be provided with itemized bills for all transportation, food and lodging expenses.

PRESCRIPTION MEDICATION BENEFIT

The prescription benefit provides benefit for expense incurred for drugs which require a written prescription (legend drugs) and which are dispensed by a licensed pharmacist. The program also provides benefit for expense for insulin, syringes for administration of insulin and glucagon emergency kits and select over-the-counter (OTC) drugs as listed on the Pharmacy Benefit Manager's list of covered OTC drugs when prescribed by a physician and dispensed by a licensed pharmacist at a retail location.

This prescription drug card benefit is administered by the prescription drug card company, hereafter referred to as the Pharmacy Benefit Manager.

Amount of Benefit

The covered person must pay a prescription Copay amount each time he/she places a prescription order. The amount of Copay he/she must pay will vary by the type of medication purchased, and the place of purchase. See Copay amounts on the Schedule of Benefits.

Allowable Covered Prescription Expense

A prescription drug order is a request for each separate prescription drug, and/or each authorized refill, if ordered by a physician.

Expense incurred for a prescription drug order for the following items will be considered allowable covered prescription expense:

- Non-injectable legend drugs
- Specialty Drugs (PBM prior authorization may be required)
- Select OTC (non-legend) covered under the prescription drug card
- Insulin on prescription, disposable insulin needles/syringes and diabetic supplies
- Glucometers and Glucagon emergency kits
- Tretinoin, all dosage forms (Retin-A), for individuals through the age of 25 years
- Oral contraceptives and patch contraceptives
- Compounded medication, if at least one ingredient is a legend drug

- Oral medications for the treatment of erectile dysfunction (Maximum quantity of 6 per 30 day period unless prior authorization is obtained)
- Prescriptions for the treatment of infertility or in vitro fertilization;
- Any drug containing nicotine or other smoking deterrent medications as required by law
- Any other drug which, under the applicable state laws, may only be dispensed upon the written prescription of a physician or other lawful prescriber.

Prescriptions Purchased at a Retail Pharmacy

You may purchase a prescription drug order at a retail pharmacy. You must pay the prescription Copay amount designated for the type of medication purchased as outlined on the Schedule of Benefits and the Pharmacy Benefit Managers formulary tiers, and then the Plan will pay the rest of the covered expense at 100%.

- The "generic prescription Copay amount" must be paid anytime you purchase a generic medication.
- The "preferred brand prescription Copay amount" must be paid anytime you purchase a preferred brand medication listed on the preferred brand medication list and for which an equivalent generic drug is not available.
- The "brand prescription Copay amount" must be paid anytime you purchase a brand medication that is not on the "preferred brand medication list" and for which an equivalent generic drug is not available.

The Retail 30 day supply Copay applies to an order at a retail pharmacy that does not exceed the lesser of 34 day supply. The Retail 60 day supply copay will apply to an order at a retail pharmacy for a 35 to 60 day supply fill. The Retail 90 day supply copay will apply to an order at a retail pharmacy for a 61 to 90 day supply fill. Specialty drugs (non-injectable) purchased at a retail pharmacy are limited to a 30 day supply and the Specialty drugs copay amount listed on the Schedule of Benefit.

The Plan will not allow more than the price the Plan has negotiated with the Pharmacy Benefit Manager for a prescription, less the prescription Copay amount for a prescription.

The Plan will not pay the difference in charge between a brand drug and a generic drug, if the generic drug has been designated an equivalent generic drug.

Prescriptions Purchased from the Mail Service Program

Up to a 90 day supply of medication can be obtained from the mail service program. You must pay the applicable mail order prescription Copay amount designated for the type of medication purchased as outlined in the Schedule of Benefits, and then the Plan will pay the rest of the covered expense at 100%.

- The "generic mail order prescription Copay amount" must be paid anytime you purchase a generic medication.
- The "preferred brand mail order prescription Copay amount" must be paid anytime you purchase a preferred brand medication listed on the preferred brand medication list and for which an equivalent generic drug is not available.

- The "brand prescription mail order Copay amount" must be paid anytime you purchase a brand medication that is not on the "preferred brand medication list" and for which an equivalent generic drug is not available.

The Mail Order 30 day supply Copay applies to an order purchased by mail order that does not exceed the lesser of 34 day supply. The Mail Order 60 day supply copay will apply to an order purchased by mail order for a 35 to 60 day supply fill. The Mail Order 90 day supply copay will apply to an order by mail order for a 61 to 90 day supply fill. Specialty drugs (non-injectable) purchased by mail order are limited to a 30 day supply and the Specialty drugs copay amount listed on the Schedule of Benefit.

The Plan will not pay more than the price the Plan has negotiated with the Pharmacy Benefit Manager, less the mail order Copay amount for a prescription.

The Plan will not pay the difference in charge between a brand drug and a generic drug, if the generic drug has been designated a generic equivalent.

How to file a Claim

To file a prescription claim at a retail pharmacy, a Participant should present his/her prescription drug card to the participating pharmacy. The pharmacist will use the information on your card to electronically file a claim with the Pharmacy Benefit Manager.

To file a claim under the Mail Service Program, a Participant must submit the original prescription and the necessary forms to the Pharmacy Benefit Manager Mail Service Program. The necessary forms and instruction brochures can be obtained from the Third Party Administrator website, www.groupplansolutions.com or by calling the Third Party Administrator.

Prescription Drug Card Exclusions

A prescription drug order does not include and no benefit will be payable for the following, regardless of the reason for which prescribed:

- The amount of expense for a medication that is in excess of the amount agreed upon between the Pharmacy Benefit Manager and the Plan Administrator;
- The difference between the cost of a Brand name drug and an equivalent generic drug, if the generic drug has been designated an equivalent generic drug by the Pharmacy Benefit Manager;
- For duplicate prescriptions or prescriptions refilled more frequently than the prescribed dosage indicates (a prescription purchased at retail pharmacy cannot be refilled until the patient has used 75% of the medication as prescribed; a prescription purchased at mail order cannot be refilled until the patient has used 60% of the medication as prescribed);
- Any prescription drug that is not intended to be self-administered;
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a Hospital, rest home, sanitarium, Skilled Nursing Facility, convalescent care facility, nursing home, or similar institution which operates

on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- Drugs dispensed by a physician
- Fluoride supplements, hematinics;
- Immunization agents, biological sera, blood or blood plasma;
- Injectable drugs, except insulin;
- Minerals;
- Minoxidil (Rogaine) for the treatment of alopecia;
- Anorexiants (any drugs used for purposes of weight control);
- Non-legend drugs other than insulin
- OTC drugs other than select OTC drugs with a written prescription covered by the prescription drug card;
- Tretinoin, all dosage forms (Retin-A), for individuals 26 years of age or older;
- Vitamins, singly or in combination, except for legend prenatal vitamins and folic acid;
- Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed under allowable covered prescription expense;
- Charges for the administration or injection of any drug;
- Prescriptions which an eligible person is entitled to receive without charge under any Worker's Compensation law;
- Drugs labeled "Caution-limited by federal laws to investigational use", or experimental/investigational drugs, even though a charge is made to the individual;
- Any charge for a prescription drug when the drug does not meet the step therapy requirements of the Pharmacy Benefit Manager.
- Any charge for more than a 90 day supply of a prescription drug;
- Any charge for a prescription drug dosage that exceeds the Pharmacy Benefit Manager's optimum dosage limits;
- For prescriptions refilled in excess of the number ordered by the physician;
- For prescriptions refilled after one year from the physician's original order;
- For prescriptions to replace lost or damaged prescriptions;
- Any charge for a prescription drug that does not meet prior authorization requirements established by the Pharmacy Benefit Manager

EXPENSE NOT COVERED BY THE PLAN

These exclusions apply to all health benefits of this plan.

This plan does not cover loss caused by:
- An act of war
- Service in the armed forces
- Suicide, attempted suicide, or intentionally self-inflicted injury to the extent allowed by law.
- Complications arising from excluded treatment, commission of a felony or illegal activities.

This Plan does not pay any benefit for expense for:
- Services that aren't medically necessary

- Services for which no benefit is defined or described in this Plan
- Incidental appendectomies
- Treatment of educational or training problems, learning disorders, marital counseling, or social counseling
- Services provided by an employee of a school district, or a person contracted to provide services for a school district, or services available through a school system
- Any experimental/investigational service, supply, or treatment
- The use of any services or facilities of a federal, Veteran's administration, state, county or municipal hospital, except where the Plan or the covered person are legally required to pay the expenses
- Treatment of an injury or illness caused by or resulting from an illness or injury of the covered person, if the illness or injury is recognized as a compensable loss by the provisions of any worker's compensation act, employer liability laws, occupational disease law, or any similar law of a state or federal government, or other governmental subdivision, under which the person is or could be protected on a mandatory basis, whether or not such protection is afforded; or would have been recognized had the covered person made claim within the appropriate time limits. If the worker's compensation type coverage has denied a claim, but the covered person is still pursuing coverage with the worker's compensation type coverage through a state or federal commission or agency, or other legal entity, benefits will not be payable under this Plan until the covered person certifies he/she no longer intends to pursue coverage through the worker's compensation type coverage
- Hearing aids, contact lenses, dentures
- Eye glasses except as provided under the section titled Covered Health Expenses Under This Plan
- Eye examinations for the correction of vision or fitting of glasses or contact lenses; Vision therapy or orthoptics treatment (eye exercises)
- Any dental treatment, dental surgery, or extractions, except that the Plan will provide coverage for:
    - The treatment of injuries to whole natural teeth. The treatment must be performed during the first 30 days after the date of injury
    - Treatment of congenital defects and birth abnormalities, including cleft palate or cleft lip, for a child
- Any orthodontic procedure or appliance
- Any service or supply not recommended or approved by a licensed medical practitioner
- Any treatment or surgery that results in the improvement of appearance, except for that which is the result of breast reconstruction following a mastectomy, or treatment of congenital defects and birth abnormalities, including cleft lip or cleft palate repair, or which is the result of an injury. The treatment must be performed during the first 12 months after the date of injury
- Services or supplies that are not for the diagnosis or treatment of an existing illness or injury, except as provided under the section titled "Preventive Care"
- Immunizations or vaccinations, except as provided under the section titled "Preventive Care"
- Abortions, except where the mother's life is threatened
- Amniocentesis, except for the diagnosis or treatment of an existing complication of pregnancy
- Reversal of sterilization procedures
- Nonmedical services and supplies
- Durable medical equipment unless the purchase or rental of the equipment has been preauthorized

- Any service or supply that the covered person is not legally required to pay for, including any forgiveness of deductible, Copay, or coinsurance by a provider or any write off of an outstanding balance by a provider
- Any surgery for the correction of a refractive error
- Treatment received in an emergency room of a hospital except when emergency services are being rendered
- The replacement of a piece of durable medical equipment or a prosthesis unless preauthorized.
- Custodial care
- Services furnished by the employee or a member of his/her or his/her spouse's immediate family, or by a person who regularly lives in his/her home
- Any medical treatment, weight reduction program, membership dues, or clinic fees for the treatment of obesity or morbid obesity except where required by law or allowed for under the Covered Health Expenses section of the Plan
- Any surgical procedure to remove excess tissue caused by weight loss
- Nutritional supplements
- Treatment of nicotine other than required by law, caffeine, gambling, computer or similar addictions
- Services provided by a midwife, except where specifically licensed by the state to practice midwifery
- By a registered nurse (RN) for private duty professional nursing services
- Sclerotherapy for varicose veins
- Sex transformation procedures, treatments, or studies
- Devices used specifically as safety items or to affect performance primarily in sports-related activities
- Medical or surgical treatment of upper or lower jaw alignment conditions or malformations, including orthognathic surgery, expect for direct treatment of acute traumatic injury or cancer
- Wigs or hair prosthesis
- Routine foot care related to corns, calluses, flat feet, fallen arches, weak feet, or chronic foot strain; shoe inserts (unless custom made); except that routine foot care for patients with diabetes will be covered
- Physical conditioning programs such as athletic training, body-building exercises, fitness and flexibility programs
- Physical therapy, occupational therapy, manipulative therapy, or speech therapy services if an expectation for practical improvement in the level of functioning within a reasonable period of time does not exist
- Any charge for therapy where the same equipment could be utilized at a health club or gym
- Physical therapy, occupational therapy, manipulative therapy, or speech therapy when the service being provided is supervised exercise, or when the service being provided does not require a licensed to be performed
- The services of a massage therapist, athletic trainer, or masseuse
- Ambulance usage when another type of transportation or another level of ambulance service could have been used without endangering the patient's health
- Any charge that does not meet the definition of regular, reasonable and customary for an otherwise covered expense
- any charge for a service that exceeds the maximum allowable amount
- care required while incarcerated in a federal, state or local penal institution or while in custody of federal, state, or local law enforcement authorities, unless otherwise required by law or regulation
- court ordered testing or care unless medically necessary or unless otherwise required by law or regulation

- surrogate parenting
- breast reduction surgery, except where required by law or allowed for under the Covered Health Expenses section of the Plan
- treatment performed outside the United States, except when an emergency
- removal of breast implants that were implanted solely for cosmetic reasons
- growth hormone treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to growth hormone deficiency, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AID wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the covered person's condition
- removal and/or replacement of a defective or recalled implant or device, or expense incurred as a result of medical malpractice
- expense that exceeds any maximum allowable amount
- self-injected prescription medications, except when pre-approved, as required by the Plan
- any oral medication intended to be self-administered except as may be provided under the Prescription Medication Benefit
- over the counter medications except as may be provided under the Prescription Medication Benefit.
- expenses for complications arising from an expense not covered by the Plan.
- Temporomandibular Joint Dysfunction

PRE-CERTIFICATION OF SERVICES

This Plan includes a utilization review program. The purpose of this program is to:

- Promote the efficient utilization of quality health care services;
- Assure the patient and payer that health care benefits are used for quality, medically necessary services
- Assure that all services are provided in the most cost effective, appropriate setting, and
- Minimize the risk of retrospective payment denials.

Services Requiring Pre-Certification by Utilization Review

You must call the Pre-certification Hotline if:

- You are being admitted as an inpatient to a hospital including observation;
- You are having a non-emergency outpatient High Tech Diagnostic Services (i.e. but not limited to MRI/MRA, CT, or PET scanning procedure).

Non-Emergency Hospitalization, Surgeries, and Procedures

You must call the Pre-Certification Hotline at least 2 business days hours before you are scheduled for a non-emergency hospital or skilled nursing facility inpatient admission, surgery, or scanning procedure.

Medical Emergency

You must call the Pre-Certification Hotline within 2 business days (or as soon as reasonably possible if your condition prevents you from calling within that time frame) after your emergency admission, or surgery.

Making the Call

You can make the phone call, or you can have a relative or your physician make the phone call. However, you are responsible for making sure that someone calls the Pre-Certification Hotline on a timely basis.

When the call is made, the following information should be available:

- The patient's name, date of birth, sex, and the member number and plan name
- The proposed (or actual) date and reason for admission, surgery, or scanning procedure
- The name and phone number for the hospital, skilled nursing facility, scanning facility and ordering physician.

Pre-certification Process

When a call is made to the Pre-Certification Hotline, the caller will be given a pre-certification number. A review determination will be made to verify medical necessity and appropriateness only.

The pre-certification process does not confirm that a provider is a PPO provider. It does not guarantee benefits for a service. If a covered person wants to know if a service approved by pre-certification will be covered under the plan, or if a provider is in-network, they must call the phone number for Group Plan Solutions.

Medical Necessity and Appropriateness

No benefit will be payable for any hospitalization or skilled nursing facility stay, surgery, or scanning procedure if it is not approved as medically necessary and appropriate by the reviewer.

Right to Appeal

You or your physician may, at any time, initiate a request for reevaluation or extension of a reviewer's decision by calling the Precertification Hotline. You may also file an appeal with the Third Party Administrator.

Failure to Precertify

If the Participant fails to pre-certify any service requiring pre-certification, the Participant will be responsible for a penalty equal 50% of the total covered expense for services received up to $1,000 maximum penalty. The Participant will also be responsible for any non covered, medically unnecessary expenses resulting from the non certified stay.

It is the responsibility of the Participant to ensure Precertification has been obtained.

CASE MANAGEMENT

Your Plan requires that certain services have Case Management prior authorization. Before obtaining these services, you must receive authorization from the Plan's case management nurse. Services requiring case management authorization are:

- Durable medical equipment
- Injectable medications (except for insulin and its administration) whether taken at home or administered in a physician's office
- Home health care
- Orthotics, prosthetics
- Most medical supplies
- Skilled nursing stays
- Hospice care
- Insulin pumps, diabetic supplies, ostomy supplies
- Purchase, refitting, or replacement of prosthetic devices
- CPAP or similar machines, oxygen equipment.
- Chemotherapy
- Inpatient Rehabilitation
- Transplants
- Home Infusion
- Genetic Testing

Not all services above may be covered under the Plan. Refer to the Schedule of Benefits, Covered Health Expenses Under This Plan section and Expenses Not Covered By The Plan section.

If a Participant is faced with a serious illness or long-term health concern, the Plan has a registered nurse available to provide assistance to manage the person's healthcare benefits more effectively.

Upon the advice of a case management professional, the Plan Administrator has the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result can be achieved without a sacrifice to quality of care for the patient.

FILING A CLAIM, CLAIM PROCEDURES, APPEAL PROCEDURES

The procedures outlined below must be followed by Participants to obtain payment of health benefits under this Plan.

Health Claims

All claims and questions regarding health claims should be directed to the Third Party Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make

decisions involving the use of discretion.

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

A call from a Provider who wants to know if an individual is covered under the Plan or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions**. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Participant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a final Adverse Benefit Determination. If the Participant receives notice of a final Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Participant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Plan Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

- Pre-service Claims. A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

  A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

  If the Plan does not require the Participant to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

- Concurrent Claims. A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

    - The Plan Administrator determines that the course of treatment should be reduced or terminated; or

    - The Participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

  If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

- Post-service Claims. A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Post-service health claims must be filed with the Third Party Administrator within 12 months of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Third Party Administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days from receipt by the Participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

- Pre-service Urgent Care Claims:

    - If the Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

- If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 72 hours after receipt of the claim.

- The Participant will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:

  - The Plan's receipt of the specified information; or

  - The end of the period afforded the Participant to provide the information.

If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

- Pre-service Non-urgent Care Claims:

  - If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

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

- Concurrent Claims:

  - Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

  - Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a Participant to extend the course of treatment

beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, as long as the Participant makes the request at least 72 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

- Request by Participant Involving Non-urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

- Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:

  - Notification to Participant 30 days

  - Notification of Adverse Benefit Determination on appeal 30 days

- Post-service Claims:

  - If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

  - If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

- Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.

- Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15- day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Extensions – Post-service Claims. This period may be extended by the Plan for up to

15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will contain the following information:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's internal appeals and external review processes and the time limits applicable to the processes. This description will include information on how to initiate the appeal following an Adverse Benefit Determination on final review;

- A statement that the Participant 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 Participant's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request;

- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes; and

- In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

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

- Participants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;

- Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.

- For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult

with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

- That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Third Party Administrator; ; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; and

- That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Participant to respond to such new evidence or rationale.

Requirements for Appeal

The Participant must file the appeal in writing (although oral appeals are permitted for pre-service urgent care claims) within [180] days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the Participant chooses to orally appeal, the Participant may telephone:

Group Plan Solutions Benefit Administration,
a Division of Pekin Insurance
2505 Court Street
Pekin, IL 61558
Phone: 888-301-0747
Fax: 309-478-2912
Email: inquiry@groupplansolutions.com
Website: www.groupplansolutions.com

To file an appeal in writing, the Participant's appeal must be addressed as follows and mailed or faxed as follows:

Group Plan Solutions Benefit Administration,
a Division of Pekin Insurance
2505 Court Street
Pekin, IL 61558

Phone: 888-301-0747
Fax: 309-478-2912
Email: inquiry@groupplansolutions.com
Website: www.groupplansolutions.com

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

- The name of the employee/Participant;
- The employee/Participant's social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

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

Timing of Notification of Benefit Determination on Review

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

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances; but not later than 30 days after receipt of the appeal.
- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim; pre-service urgent, pre-service non-urgent or post-service.
- Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to

all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;

- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal following an Adverse Benefit Determination on final review;

- A statement that the Participant 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 Participant's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and

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

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review

If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

External Review Process

A. Scope

1. The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

2. The Federal external review process applies only to:

   (a) An Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and
   (b) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

B. Standard external review

Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. 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 health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

(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 (e.g., worker classification or similar determination);

(c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; 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 will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. 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. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Third Party Administrator to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

C. Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:

(a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations 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) A final internal Adverse Benefit Determination, 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.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.

3. Referral to independent review organization. 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 set forth in paragraph A.3 above for standard review. The Plan will 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 them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Third Party Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

COORDINATION WITH MEDICARE AND MEDICAID

MEDICARE

When Medicare is primary payer, the Plan will coordinate the Plan benefits with Medicare in accordance with the "Coordination of Benefits" provision in this Plan.

If a covered person is eligible for Medicare as primary payer, but does not enroll or apply for it on time, the Plan will estimate what Medicare would have paid if the covered person had made timely application.

The Plan Administrator will determine if Medicare is primary payer based upon Medicare regulations and the status of the Participant on the date a covered expense is incurred.

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 Persons 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. 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.

COORDINATION OF BENEFITS

When the Plan is the secondary plan, the plan will determine the Regular, Reasonable, and Customary Charge. After the primary plan pays, the Plan will either pay what is left of the Regular, Reasonable and Customary Charge or the regular benefit, whichever is less. The Plan will not pay more than the Regular, Reasonable and Customary Charge amount. The secondary plan pays a reduced amount, which when added to the benefits paid by the primary plan, will normally equal 100% of the allowable expense. The benefits payable under the secondary plan cannot exceed the benefit that would be payable if there was no other group-type plan.

RULES FOR ORDER OF PAYMENT

The primary plan is:

- The plan which does not coordinate its benefits with any other plan.
- The plan which covers the person as an employee or student, rather than as a dependent. However, if a person is also a Medicare beneficiary, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent, for example a retired employee.
- The plan of the parent whose birthday (excluding year of birth) occurs earlier in a calendar year, if both parents are living together. If both parents have the same birthday, the plan that has covered a parent the longest is primary. If the other plan does not have this provision in their policy, then the plan which covers the father as an employee will be primary, rather than the plan which covers the mother as an employee.
- The plan of the parent with custody of the child, if the parents are divorced or separated. The secondary plan will be the plan of the spouse of the parent with custody. The final plan will be the plan of the parent without custody.
- If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, then the plan of the parent who has responsibility will be primary over the other parent or stepparent's plan. This provision does not apply until the Plan has been informed of the terms of the court decree. Any benefits paid prior to the Plans knowledge of the terms of the court decree will be subject to the other sections of this provision.
- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of

the child, then the plan of the parent whose birthday occurs earlier in the calendar year is primary.

- The plan which covers a person as an active employee, rather than the plan which covers the person as a laid-off or retired employee. The primary plan is the plan which covers the person as a dependent of an active employee, rather than the plan which covers the person as a dependent of a laid-off or retired employee.
- The plan which covers the person as an employee, or the dependent of an employee, rather than the plan which covers the person under any continuation coverage. If the other plan does not have a rule regarding continuation coverage, and as a result, the plans do not agree on which plan is primary, then this rule will be ignored.
- If none of the above rules apply, then the plan which has covered the Participant the longest is the primary plan. The length of time a person has been covered under a plan is measured from the claimant's first date of continuous coverage under the Plan.

REIMBURSING THE OTHER PLAN

If another plan has paid their benefit in error according to this provision, the Plan can make payment directly to them to satisfy the intent of this provision. Any payment made by the Plan for this reason will fully discharge the Plan Administrator of any liability under this plan.

HEALTH INSURANCE CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under certain circumstances, you have the right to temporarily extend your health coverage under this plan under a federal continuation provision called COBRA. COBRA continuation coverage is a continuation of health coverage when coverage would otherwise end because of a life event known as a "qualifying event". After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse and your dependent children could become qualified beneficiaries if coverage under this plan is lost because of a qualifying event.

The health coverage that will be extended is the same coverage that is provided to active covered employees.

Qualified beneficiaries who elect COBRA continuation coverage must pay the premiums for COBRA continuation coverage.

WHEN YOU BECOME A QUALIFIED BENEFICIARY

If you are a covered employee, you will become a qualified beneficiary if you lose your coverage under this plan because of one of the following qualifying events:

- Your hours of employment are reduced
- Your employment ends for any reason other than your gross misconduct.

If you are the covered spouse of an employee, you will become a qualified beneficiary if you lose your coverage under this plan because any of the following qualifying events happens:

- Your spouse dies
- Your spouse's hours of employment are reduced
- Your spouse's employment ends for any reason other than his/her gross misconduct
- Your spouse becomes entitled to Medicare benefits under Part A, Part B, or both
- You become divorced or legally separated from your spouse.

A covered dependent child will become a qualified beneficiary if he/she loses coverage under this plan because any of the following qualifying events happens:

- The covered employee parent dies
- The covered employee parent's hours of employment are reduced
- The covered employee parent's employment ends for any reason other than his/her gross misconduct
- The covered employee parent becomes entitled to Medicare benefits under Part A, Part B, or both
- The parents become divorced or legally separated
- The child no longer meets the definition of a dependent child under this plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan Administrator, or the Plans designated representative, will notify you of your right to continue coverage under COBRA once the Plan has been notified that a qualifying event has occurred. The Plan Administrator will be aware when the qualifying event is end of employment or reduction of hours of employment, death of the employee.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For all other qualifying events, you must notify the Plan Administrator, or the Plan's designated representative, in writing of the qualifying event within 60 days after the event occurs. If the Plan Administrator, or the Plan's designated representative, is not notified within this time frame, COBRA continuation cannot be offered. In order to take advantage of the disability extension, you must also notify the Plan within sixty days of a determination by Social Security that you or a dependent are disabled. It is important for each covered person and covered dependent to timely provide the Employer with his current mailing address.

THE PLAN ADMINISTRATORS NOTIFICATION RESPONSIBILITIES

Once the Plan Administrators, or the Plans designated representative, receive notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their children.

COBRA ELECTION PERIOD

You or your dependents have the responsibility to notify the Plan, or the Plan Administrator's designated representative, of your desire to continue coverage within sixty days from the later of the date of notification or loss of coverage. Upon acceptance, you or your dependent will be notified of any enrollment forms that must be completed. Qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date termination from the Plan would have occurred.

If a covered person decides to continue this coverage, the first premium payment is due 45 days following the date he/she returns the election form. Coverage is provided only when the full premium for the applicable period is received. The covered person must pay any premiums after that within 30 days of the date the premium is due. Premium payments must be made to the Plan, or the Plan Administrators designated representative. Coverage is not in force for any period for which premium is not paid.

If you or a covered dependent experience a qualifying event and do not receive a qualifying event notification in a timely fashion, you should contact the Plan, or the Plan Administrator's designated representative, immediately.

LENGTH OF CONTINUATION

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled and you notify the Plan in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the social security Administration determination must be provided to the Plan Administrator within 60 days of the date of the determination and prior to the end of the 18th month of continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your covered spouse and covered dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

PERSONS WHO CANNOT CONTINUE

A covered person cannot continue this coverage under the COBRA continuation provision if:

- They are considered a spouse under the plan due to a state law that recognizes a same sex domestic partner as a spouse.
- At the time of his/her termination, the covered person is a nonresident alien with no earned income from sources within the United States, or is the dependent of such person.

COBRA TERMINATION

Although COBRA continuation coverage has a maximum time frame, you may voluntarily terminate coverage at any time by notifying the Plan, or the Plan Administrator designated representative, in advance. In addition, COBRA states that continuation coverage will end for one or more of the following reasons:

- The date the maximum continuation period has been exhausted
- The date the employer ceases to maintain any group health plan for any employee
- The date the covered person is covered by another group health plan which does not include a preexisting condition clause or which would have the preexisting condition limitation period reduced by qualifying previous coverage
- The date the covered person becomes covered by Medicare Part A and/or Part B
- The date any premium that is due is not paid within the time allowed.

A covered person's continuation under this Plan will terminate anytime this Plan is terminated.

GENERAL PROVISIONS

RIGHT TO RECOVERY

If the Plan made a payment in error, the Plan can recover the Plan's payment from another plan, the Participant, or anyone else to whom the Plan has made payment.

PHYSICAL EXAMINATIONS

The Plan Administrator reserves the right to have a Physician of the Plan's choosing examine any Participant whose condition, illness or injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

AUTOPSY

The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, illness, or injury is the basis of a claim. This right may be exercised only where not prohibited by law.

PAYMENT OF BENEFITS

All benefits under this Plan are payable to the covered employee whose illness or injury, or whose covered dependent's illness or injury, is the basis of a claim. In the event of the death or incapacity of a covered employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any

and all such payments to the individual or institution which, in the opinion of the Plan, is or was providing the care and support of such Employee.

ASSIGNMENTS

Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered employee and the assignee, has been received before the proof of loss is submitted.

No participant shall at any time, either during the time in which he or she is a participant in the Plan, or following his or her termination as a participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or dependent on whose behalf such payment was made.

A Plan Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other

injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

- In error;
- Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
- Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
- With respect to an ineligible person;
- In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
- Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his Covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the plan participant for any outstanding amount(s).

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in

those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Participant(s) fails to file a claim or pursue damages against:

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- worker's compensation or other liability insurance company; or any other source including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance

1. If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

    a) the responsible party, its insurer, or any other source on behalf of that party;
    b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
    c) any policy of insurance from any insurance company or guarantor of a third party;
    d) worker's compensation or other liability insurance company; or
    e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance

Separation of Funds

1. Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

1. In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Participant(s) and all others that benefit from such payment.

Obligations

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

    a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
    c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
    d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
    e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
    f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

2. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

Offset

1. Failure by the Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

Minor Status

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

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

Language Interpretation

1. The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

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

PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services.

Plan Administrator

The Plan is administered by the Plan Administrator, and in accordance with the plan provisions. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

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 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 (including the determination of what services, supplies, care and treatments are Experimental/Investigational)
- to decide disputes which may arise relative to a Participant's rights, and
- to decide questions of Plan interpretation and those of fact relating to the Plan.

The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

- to administer the Plan in accordance with its terms
- to determine all questions of eligibility, status and coverage under the Plan
- to interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms
- to make factual findings
- to decide disputes which may arise relative to a participant's rights and/or availability of benefits
- to prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials
- to keep and maintain the Plan documents and all other records pertaining to the Plan
- to appoint and supervise a Third Party Administrator to pay claims
- to establish and communicate procedures to determine whether a medical child support order is a QMCSO
- to delegate to any person or entity such powers, duties and responsibilities as it deems appropriate, and
- to perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settler of the Plan, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents.

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

HIPAA PRIVACY

Right to Receive and Release Information

The Third Party 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 Third Party 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 Third Party 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 Third Party 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.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

ANNUAL NOTICE TO HEALTH PLAN PARTICIPANTS

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to provide participants with notices of their rights under WHCRA, to provide certain benefits in connection with a mastectomy, and to provide other protections for participants undergoing mastectomies.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was
- performed; Surgery and reconstruction of the other breast to produce a
- symmetrical appearance;
- Protheseses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance amounts applicable to other medical and surgical benefits provided under this health plan.

Please keep this information with your other group health plan documents. If you have any questions about the Plan's coverage of mastectomies and reconstructive surgeries, please call Group Plan Solutions at 888-301-0747.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

ANNUAL NOTICE TO HEALTH PLAN PARTICIPANTS

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group health plans from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth:

- following a normal vaginal delivery to less than 48 hours,
- and following a cesarean section, to less than 96 hours.

The Plan may not require that a provider obtain authorization from us for prescribing any such length of stay. Regardless of these standards, an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, the Plan may not:

- deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage
- provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage
- provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay
- coverage require a mother to give birth in a hospital
- restrict benefits for any portion of a period within a hospital length of stay described in this notice.
- These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description.