Jefferson Local Schools
Health Benefit Plan

July 1, 2016

Summary Plan Description

Welcome to the Jefferson Local Schools Health Benefit Plan.

The purpose of this Health Benefit Plan is to help protect you and your family from the financial burden which may arise as a result of an unexpected accident or illness.

This Plan is as comprehensive as possible and offers you the flexibility of choosing your health care provider while encouraging you to use the plan wisely.

We encourage you to become familiar with the contents of this Summary Plan Description to help you understand the benefits available to you. If, after reviewing the Summary Plan Description, you have any questions, please contact your Human Resource Representative or HealthSmart Benefit Solutions, Inc.

Sincerely,

Jefferson Local Schools

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JEFFERSON LOCAL SCHOOLS
HEALTH BENEFIT PLAN

This booklet provides you with a "Summary Plan Description" of your Health Benefit Plan. You will notice that a brief description of your benefits is provided for your convenience.

While this booklet describes the principal provisions of your Plan in simplified terms, it is not a contract, and will not be binding over a Plan provision. The administration of your Plan is subject to the actual terms and provisions of the Plan as set forth in the formal Plan Document. This description is intended only to help you understand the Plan and can in no way be considered to modify the actual terms and provisions as specified in the Plan Document.

The following important information is provided to help you understand your legal rights under the Plan.

The Plan has specific conditions that you must meet to be eligible to receive benefits. Please see the "Employee Eligibility" and "Dependent Eligibility" sections in this booklet. This booklet, called a Summary Plan Description, describes the benefits that are available under the Plan. Please see the "Schedule of Benefits" and the "Description of Coverage" sections.

Circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of any benefits are described in the "Schedule of Benefits", "Exclusions", "Termination of Employee Coverage" and "Termination of Dependent Coverage" sections of this booklet. You may also lose benefits if you defraud the Plan, or if the Employer is unable to pay benefits.

The Plan can be amended, discontinued or terminated at any time without prior notice to you. Any such change in coverage takes effect immediately for you and your Dependents whether or not you are actively at work. This revised Summary Plan Description booklet includes Plan amendments effective on or before July 1, 2016.

I
PLAN INFORMATION

Name and Type of Plan

The name of the Plan is the Jefferson Local Schools Health Benefit Plan. The Plan provides medical, dental, prescription drug and vision benefits.

Name and Address of the Employer

Jefferson Local Schools
906 West Main Street
West Jefferson, Ohio 43162
(614) 879-7654

Plan Sponsor

The Employer named above is the Plan Sponsor.

Plan Administrator

The Plan Sponsor named above is the Plan Administrator. The Plan Administrator has the discretionary authority to interpret the Plan, including those provisions relating to eligibility and benefit determination. The Plan Administrator's interpretations and determinations are final and binding.

Agent for Service of Legal Process

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

Plan Trustees

None

Type of Administration of the Plan

The Plan provides benefits through the Jefferson Health Plan (formerly known as the Ohio Mid-Eastern Regional Education Service Agency OME-RESA Health Benefits Consortium). The Plan is administered directly by the Plan Administrator with claims being paid on behalf of the Plan by the Claims Administrator, HealthSmart Benefit Solutions, Inc., 3320 W. Market Street, Suite 100, Fairlawn, Ohio, 44333, in accordance with the provisions of the Plan Document. HealthSmart Benefit Solutions, Inc. is the designated claims paying agent only and does not insure or underwrite the liability of the Jefferson Health Plan or the liability of the Employer under the Plan. The Employer shall determine the benefits to be provided by or through the Plan, and the Employer has elected to join the Jefferson Health Plan in order to participate in that cooperative program of health care benefits. The Jefferson Health Plan (formerly known as the Ohio Mid-Eastern Regional Education Service Agency OME-RESA) is a Regional Council of Governments, 2023 Sunset Boulevard, Steubenville, Ohio, organized under the Ohio Revised Code.

Funding and Source of Contributions

The Plan is a funded Plan. The Employer's purchase payment for medical benefits is a fixed amount as determined periodically by the Jefferson Health Plan (formerly known as the Ohio Mid-Eastern Regional Education Service Agency OME-RESA Health Benefits Consortium) in an amount necessary to participate in Jefferson Health Plan. The Jefferson Health Plan is a self-insurance pool that provides health insurance coverage for participating members. The Jefferson Health Plan pays covered claims to service providers and recovers these costs from charges to participating members based on an actuarially determined cost per employee.

The Employer and its covered employees are the source of contributions to the Plan. The employee contribution is a fixed amount as determined periodically by the Employer.

Plan Year

The fiscal records of the Plan are kept on a Plan Year basis ending on each June 30.

Internal Revenue Service Identification Numbers

Plan Identification Number (EIN) for the Jefferson Health Plan
(formerly Ohio Mid-Eastern Regional Education
Service Agency OME-RESA): 34-1771649

Plan Administrator Identification Number (EIN) for the
Jefferson Local Schools: 31-6400595

Collective Bargaining Agreement

The Plan is maintained pursuant to a collective bargaining agreement. An employee may obtain a copy of the agreement by contacting local union representatives or an employee may examine such agreement during normal working hours at the office of the Plan Administrator.

II
SCHEDULE OF BENEFITS

Non-Grandfathered Plan under the Patient Protection and Affordable Care Act

The Plan will pay, after satisfaction of the specified Deductible Amount, the Benefit Percentage indicated in the Schedule of Benefits, subject to the specified maximums.

The level of benefits payable under this Plan depends upon whether a Covered Person chooses to obtain medical care from a Network or Non-Network Provider. The Plan encourages the selection of a Network Provider by paying higher benefits when a Covered Person obtains medical care from a Network Provider.

Certain facilities, medical centers, and medical providers have been designated as Network Providers under this Plan. Treatment obtained from any Network Provider is payable as specified in the Schedule of Benefits under Network benefits.

All other medical providers and facilities are considered Non-Network Providers. Treatment obtained from any Non-Network Provider is payable as specified in the Schedule of Benefits under Non-Network benefits.

Network Provider benefits will be paid for Non-Network Providers in the following circumstances:

(1) Student Dependents living outside the Network service area who are treated by Non-Network Providers while attending school or Covered Persons visiting outside the Network service area who require Medically Necessary care.
(2) Referrals by Network Providers.
(3) Emergency Treatment of an Injury or an Acute Medical Condition.
(4) Charges made by Non-Network Providers for services that are not available within the scope of the Network.

Network Provider benefits will be paid for certain Network Facility-affiliated Physicians and medical providers who are Non-Network Providers. This includes but is not limited to charges for anesthesiologists and emergency room Physicians and the professional component charges for pathology and radiology. Charges made by a Facility-affiliated Physician or medical provider must be Reasonable and Customary as determined by the Plan.

Charges made by a Non-Network Provider may exceed the Reasonable and Customary (R&C) amount for such procedures and a Covered Person may be balance billed for the difference. A Covered Person will not be balance billed for procedures performed by a Network Provider in excess of the Network Provider fee schedule.

Any amount applied toward the Network Calendar Year Deductible Amount will be applied toward the Non-Network Calendar Year Deductible Amount, and vice versa.

Any amount applied toward the Network Out-of-Pocket Maximum will be applied toward the Non-Network Out-of-Pocket Maximum, and vice versa.

Overall Annual Maximum ..... Unlimited

Overall Lifetime Maximum ..... Unlimited

Hospital Emergency Room Copayment ..... $75 (waived if admitted)
(also one visit allowed without a Copayment per 12 month period beginning each January 1st)

Routine Physical Examinations ..... Payable as specified under the "evidence-based preventive services benefit" of the Patient Protection and Affordable Care Act

Bone Density Tests ..... Payable as specified under the "evidence-based preventive services benefit" of the Patient Protection and Affordable Care Act

CLASSIFIED PERSONNEL

Calendar Year Deductible Amount

Network

Individual	$250
Family	$500

Non-Network

Individual	$400
Family	$800

Benefit Percentage (paid by the Plan)

Network ..... 85% of the Network Provider Charge unless specifically noted otherwise

Non-Network .... 70% of the Reasonable & Customary Charge (R&C) unless specifically noted otherwise

Out-of-Pocket Maximum (Includes the Calendar Year Deductible Amount)

Network

Individual	$1,050
Family	$1,900

Non-Network

Individual	$1,500
Family	$2,400

The Comprehensive Major Medical Expense Coverage Out-of-Pocket Maximum is the most a Covered Person will pay during a Calendar Year before the Plan begins to pay 100% of Eligible Expenses without cost-sharing to the Covered Person. This limit never includes balance-billed charges, health care the Plan doesn't cover, or contributions a Covered Person pays toward the cost of coverage.

The Out-of-Pocket Maximum under the Comprehensive Major Medical Expense Coverage portion of this Plan is separate from, and will not be used to satisfy any Copayments, Deductible or Out-of-Pocket Maximum under the Prescription Drug Expense Coverage portion of this Plan, or vice versa. After a Covered Person has satisfied the Comprehensive Major Medical Expense Coverage Individual or Family Out-of-Pocket Maximum, the Plan will pay 100% of the cost of Medically Necessary Eligible Expenses that are incurred under the Comprehensive Major Medical Expense Coverage for the remainder of the Calendar Year.

CERTIFIED PERSONNEL

Calendar Year Deductible Amount

Network

Individual	$250
Family	$500

Non-Network

Individual	$400
Family	$800

Benefit Percentage (paid by the Plan)

Network ..... 85% of the Network Provider Charge unless specifically noted otherwise

Non-Network .... 70% of the Reasonable & Customary Charge (R&C) unless specifically noted otherwise

Out-of-Pocket Maximum (Includes the Calendar Year Deductible Amount)

Network

Individual	$1,050
Family	$1,900

Non-Network

Individual	$1,500
Family	$2,400

The Comprehensive Major Medical Expense Coverage Out-of-Pocket Maximum is the most a Covered Person will pay during a Calendar Year before the Plan begins to pay 100% of Eligible Expenses without cost-sharing to the Covered Person. This limit never includes balance-billed charges, health care the Plan doesn't cover, or contributions a Covered Person pays toward the cost of coverage.

The Out-of-Pocket Maximum under the Comprehensive Major Medical Expense Coverage portion of this Plan is separate from, and will not be used to satisfy any Copayments, Deductible or Out-of-Pocket Maximum under the Prescription Drug Expense Coverage portion of this Plan, or vice versa. After a Covered Person has satisfied the Comprehensive Major Medical Expense Coverage Individual or Family Out-of-Pocket Maximum, the Plan will pay 100% of the cost of Medically Necessary Eligible Expenses that are incurred under the Comprehensive Major Medical Expense Coverage for the remainder of the Calendar Year.

ADMINISTRATIVE PERSONNEL

Calendar Year Deductible Amount

Network

Individual $250
Family $500

Non-Network

Individual $400
Family $800

Benefit Percentage (paid by the Plan)

Network ..... 85% of the Network Provider Charge unless specifically noted otherwise

Non-Network .... 70% of the Reasonable & Customary Charge (R&C) unless specifically noted otherwise

Out-of-Pocket Maximum (Includes the Calendar Year Deductible Amount)

Network

Individual $1,050
Family $1,900

Non-Network

Individual $1,500
Family $2,400

The Comprehensive Major Medical Expense Coverage Out-of-Pocket Maximum is the most a Covered Person will pay during a Calendar Year before the Plan begins to pay 100% of Eligible Expenses without cost-sharing to the Covered Person. This limit never includes balance-billed charges, health care the Plan doesn't cover, or contributions a Covered Person pays toward the cost of coverage.

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ALL EMPLOYEES (unless specifically noted otherwise

Benefit Limits and Maximums

Spinal Manipulation Treatment .....25 visits per Calendar Year

Routine Pap Test, Mammogram and Prostate Exam ..... Payable as specified under the "evidence-based preventive services benefit" of the Patient Protection and Affordable Care Act

Well Child Care ..... Payable as specified under the "evidence-based preventive services benefit" of the Patient Protection and Affordable Care Act

Skilled Nursing Facility ..... 120 days per Calendar Year

Home Health Care .....120 visits per Calendar Year

Hospice Care .....180 days - lifetime maximum

Tissue and Organ Transplants ... Concurring second surgical opinion required for specified transplants listed in the description section

Evidence-Based Preventive Services Benefit

In compliance with the Patient Protection and Affordable Care Act of 2010, this Plan includes as Eligible Expenses "evidence-based preventive services" without cost sharing to the Covered Person, when such preventive services are obtained through a Network medical provider. That means the Plan pays 100% of the maximum Eligible Expense. **Coverage under this preventive services benefit is not available when furnished by Non-Network medical providers.**

Preventive services include Outpatient services and office services. Screenings and other services are covered as Preventive care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Some of the most common examples of these services are health screenings for:

- Breast cancer
- Colorectal cancer / colonoscopy
- Type 2 Diabetes Mellitus
- Child and Adult Obesity
- Hearing Screening for Young Children
- Routine Physical (Exam & Immunizations) (tetanus, rabies, meningococcal, Hepatitis B, influenza, Human Pappillomavirus (HPV), MMR (measles, mumps, & rubella), varicella (VSV), & pneumococcal polysaccharide)
- Smoking Cessation Counseling
- Cervical cancer
- High Blood Pressure
- Cholesterol
- Prostate cancer
- Vision Screening for Young Children
- Well Baby Care (Exam & Immunizations)
- Well Woman Visits / Gynecological Pelvic Exam / PAP / Contraceptive Counseling / Methods
- Prostate Screening / CA-125 / SMAC / CBC
- Routine Prenatal Care

Evidence-Based Preventive Services Benefit (continued)

Covered Persons who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive care for that condition but instead benefits will be considered under the regular cost sharing provisions of the Plan. That means the Plan may not pay 100% of the maximum Eligible Expense.

Preventive services in this section shall meet requirements as determined by federal law. "Evidence-based preventive services" are those items and services as described below or as defined under the Patient Protection and Affordable Care Act including:

Categories of Covered Evidence-Based Preventive Services

- Evidence-based items/services rated A or B in the current recommendations of the U.S. Preventive Services Task Force. This includes the recommendations for routine colonoscopies.
- Routine immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- Evidence-informed preventive care and screenings for infants, children and adolescents in the comprehensive guidelines of the Health Resources and Services Administration.
- Evidence-based preventive care and screenings for women described in the comprehensive guidelines of the Health Resources and Services Administration

For a complete detailed list of preventive services you can view the federal government websites:

http://www.healthcare.gov/prevention/

http://www.cdc.gov/vaccines/pubs/ACIP-list.htm

http://www.hrsa.gov/womensguidelines/

http://www.uspreventiveservicestaskforce.org/uspstf08/colocancer/colors.htm

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This Plan intends to comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended from time to time, that requires equity in the provision of mental health and substance-related disorder benefits under group health plans. Mental health and substance use disorder benefits are defined broadly to mean benefits with respect to services for mental health conditions and substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law. The MHPAEA does not mandate mental health or substance use benefit coverage. However, if a plan offers such coverage, it must be provided at parity in accordance with this Act

The MHPAEA mandates that financial requirements and treatment limitations applicable to mental health/substance use disorder benefits may not be more restrictive than those requirements and limitations placed on medical/surgical benefits.

This equity in coverage will apply to all financial requirements, including deductibles, copayments, coinsurance, and out-of-pocket expenses, and to all treatment limitations, including frequency of treatment, number of visits, days of coverage, or other similar limits.

A group health plan (or coverage) that provides out-of-network coverage for medical/surgical benefits must also provide out-of-network coverage, at parity, for mental health/substance use disorder benefits.

The MHPAEA is protective of any applicable State law. Only a State law that "prevents the application" of this Act will be preempted which means that stronger State parity and other consumer protection laws, if applicable, remain in place.

This Plan shall provide benefits for the diagnosis and treatment of "Biologically Based Mental Illness" on the same terms and conditions as, and shall provide benefits no less extensive than those provided under the Plan for the treatment and diagnosis of all other Illnesses. "Biologically Based Mental Illness" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American Psychiatric Association. Any Plan limits and maximums pertaining to Substance Abuse treatment, and any Plan limits and maximums pertaining to Mental Illness treatment other than treatment of a "Biologically Based Mental Illness" as specifically defined above, remain in effect.

PRESCRIPTION DRUG EXPENSE COVERAGE

The purchase of drugs through CVS Caremark Pharmacy Network stores maximizes prescription drug benefits. At any pharmacy outside the CVS Caremark Network, the Covered Person will have to pay the full cost of the prescription at the time of purchase. The Covered Person is then responsible for filing a claim form for reimbursement. Prescription Drug Expense Coverage claim forms that include specific instructions on claim filing can be obtained from the Employer or HealthSmart Benefit Solutions, Inc. Direct reimbursement prescription drug claim forms must not be mailed to HealthSmart Benefit Solutions, Inc. but to the address indicated on the claim form. A Covered Person may call 1-877-860-6415 to determine if a pharmacy is a member of the CVS Caremark Network. Prescription charges in excess of the amount charged by stores in the CVS Caremark Pharmacy Network, or charges in excess of amounts allowable under any "Maximum Allowable Cost" program, will be the responsibility of the Covered Person.

Copayment per Covered Prescription or refill (retail pharmacy)
(up to a 34 day supply)

Generic	$10.00
Formulary	$25.00
Non-Formulary	$40.00

Copayment per Covered Prescription or refill (retail pharmacy)
(90 day supply)

Generic	$15.00
Formulary	$37.50
Non-Formulary	$60.00

Copayment per Covered Prescription or refill (mail service)
(90 day supply)

Generic	$15.00
Formulary	$37.50
Non-Formulary	$60.00

Benefit Percentage 100%

Prescription Drug Expense Coverage Out-of-Pocket Maximum

Network

Individual	$5,550
Family	$11,300

The Prescription Drug Expense Coverage Out-of-Pocket Maximum is the most a Covered Person will pay during a Calendar Year before the Plan begins to pay 100% of Eligible Expenses without cost-sharing to the Covered Person. This limit never includes balance-billed charges, health care the Plan doesn't cover or contributions a Covered Person pays toward the cost of coverage.

The Out-of-Pocket Maximum under the Prescription Drug Expense Coverage portion of this Plan is separate from, and will not be used to satisfy any Copayments, Deductible or Out-of-Pocket Maximum under the Comprehensive Major Medical Expense Coverage portion of this Plan, or vice versa. After a Covered Person has satisfied the Prescription Drug Expense Coverage Individual or Family Out-of-Pocket Maximum, the Plan will pay 100% of the cost of Medically Necessary Eligible Expenses that are incurred under the Prescription Drug Expense Coverage for the remainder of the Calendar Year.

DENTAL EXPENSE COVERAGE

Calendar Year Maximum for Other than Orthodontic Services $1,500

Orthodontic Lifetime Maximum $1,500

Calendar Year Deductible Amount

Individual $25
Family $75

The Deductible Amount is waived for Preventive & Diagnostic Services, Orthodontic Services and Occlusal Guards. Both employee and spouse are eligible for Orthodontic Services. Orthodontic Services are an Eligible Expense for a Dependent child under age 19 only.

Benefit Percentage

Preventive & Diagnostic Services	100% of R&C
Basic Restorative Services	80% of R&C
Major Restorative Services	50% of R&C
Orthodontic Services	60% of R&C
Occlusal Guards	85% of R&C

VISION EXPENSE COVERAGE

Calendar Year Deductible Amount $10

(all services are subject to this Deductible Amount except for the actual charge for necessary contact lenses)

Benefit Maximums

Vision Examination

Optometrist $50
Ophthalmologist $50
Contact Lenses Fitting / Evaluation Examination $50

Lenses (per pair)

Single Vision $50
Bifocal $50
Trifocal $70
Lenticular $80

Contact Lenses (necessary)

Soft ..... No Maximum
Hard ..... No Maximum
Gas Permeable ..... No Maximum

Contact Lenses (cosmetic)

Soft ..... No Maximum
Hard ..... No Maximum
Gas Permeable ..... No Maximum
Disposable ..... No Maximum

Frames $200

Benefit Period

Vision Examination	Once per Calendar Year
Frames and Lenses*	Once per Calendar Year
Contact Lenses Fitting / Evaluation Examination	Once per Calendar Year

*Benefits payable for contact lenses will be in lieu of all other frames and lenses benefits for the Benefit Period.

III
ELIGIBILITY FOR COVERAGE

Eligibility Requirements: To become eligible for coverage, you must be a member of the following Employee Class and complete the specified Waiting Period:

Employee Class:	All Active Contracted Employees. (See Definitions Section)
Waiting Period:	Eligibility begins on the first day of the month following date of hire.

Employees may be required to contribute to the cost of coverage for themselves or their Dependents as specified in the Source of Contribution provision of this booklet.

Employee Eligibility

If you are a member of an eligible Employee Class, you will become eligible for coverage under this Plan on the later of: (1) the effective date of this Plan; or (2) the first day of the month following date of hire.

If both husband and wife are employed by the Employer, either the husband or wife, but not both, may choose to be covered as an employee and include his or her spouse as a Dependent along with any eligible Dependent children.

No one can be covered under this Plan as both an employee and Dependent.

Dependent Eligibility

Your Dependent will become eligible for coverage under this Plan on the later of: (1) the date you become an Eligible Person; or (2) the date your Dependent meets the Plan's definition of Dependent.

Source of Contribution

The Comprehensive Major Medical Expense Coverage, Prescription Drug Expense Coverage, Dental Expense Coverage and Vision Expense Coverage for employees and Dependents are contributory coverages.

Employee Coverage

Your coverage will become effective on the date you become an Eligible Person, provided you have elected coverage by completing an enrollment form within 30 days of your date of eligibility.

Dependent Coverage

Coverage for your Dependent will become effective on the date your Dependent becomes an Eligible Person, provided Dependent coverage has been elected by completing an enrollment form within 30 days of your Dependent's date of eligibility.

When you are already enrolled for Dependent coverage, any additional Dependents will automatically become covered. (An enrollment form must be completed for administrative purposes.)

In no event will coverage for your Dependent begin before your coverage begins.

Late Enrollees

If you or your eligible Dependents do not enroll for Contributory coverage within 30 days of becoming eligible, you and/or your Dependents will be considered a Late Enrollee. **A Late Enrollee will not be accepted for coverage under this Plan should he subsequently wish to enroll, unless the employee or Dependent later qualifies as a "Special Enrollee" or later qualifies for enrollment under another eligibility provision of this Plan.**

If an employee and/or his eligible Dependent(s) are covered under another plan and subsequently involuntarily lose such coverage, such individuals will not be considered Late Enrollees should they wish to enroll in this Plan. Such individuals will be eligible to enroll immediately in the Plan as of the date of loss of other coverage. Application for coverage must be made within 30 days of the loss of other coverage.

Special Enrollment

If you decline enrollment for yourself or your Dependent (including your spouse) because of other health coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new Dependent (but not any other Dependents), provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

An employee or Dependent is entitled to Special Enrollment if (1) the employee has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, or (2) enrollment was previously declined because of other health coverage and the employee or Dependent has lost such other coverage, provided however:

If the other health coverage is COBRA continuation coverage, an employee or Dependent is only entitled to enroll as a Special Enrollee after the COBRA continuation period is exhausted;

If the other health coverage is not COBRA continuation coverage, an employee or Dependent is only entitled to enroll as a Special Enrollee after (i) eligibility for such other coverage is lost or (ii) employer contributions for such other coverage ceases; and

If the other coverage is lost due to the employee's or Dependent's failure to pay contributions, premiums, or for causes (such as filing fraudulent claims), the employee or Dependent has no right to enroll as a Special Enrollee.

"Special Enrollee" means an employee or Dependent who is entitled to Special Enrollment and requests Special Enrollment (i) within thirty

(30) days of losing other health coverage, or (ii) for a newly added Dependent, within thirty (30) days of the marriage, birth, adoption, or placement of adoption.

The term "Special Enrollee" also means an employee or Dependent who is entitled to and who requests Special Enrollment within sixty (60) days of losing Medicaid or Children's Health Insurance Coverage (CHIP) due to loss of eligibility, as well as obtaining eligibility for a state premium assistance subsidy under these two programs.

Special Enrollees will not be considered to be Late Enrollees for any purpose under the Plan.

Coverage will become effective for a Special Enrollee (other than a newborn or newly adopted Dependent child) as of the date of loss of other coverage or the first day of eligibility under this Special Enrollee provision, subject to the Plan's timely receipt of the enrollment application. Coverage for a newborn or newly adopted Special Enrollee shall be effective as of the date of the adoption, birth, or placement for adoption, subject to the Plan's timely receipt of the enrollment application.

Open Enrollment

The following open enrollment period is offered by the Employer for employees and their Dependents.

(1) Open Enrollment Period: August 1-August 30
(2) Effective Date of Coverage: September 1

Any enrollee who becomes covered under this Plan by virtue of this open enrollment period will be subject to all provisions and limitations of this Plan, except the Late Enrollee restrictions will not apply.

Termination of Employee Coverage

Your coverage will terminate on the earliest of: (1) the date the Plan terminates; (2) the end of the month in which you cease to be in an eligible Employee Class; (3) the date all coverage or certain benefits are terminated for your class by modification of the Plan; (4) the date you become a full-time member of the armed forces of any country; or (5) the date you fail to make any required contribution.

Termination of Dependent Coverage

Coverage for your Dependents will terminate on the earliest of: (1) the date your coverage terminates; (2) the date Dependent Coverage under the Plan terminates; (3) the date your Dependent becomes a full-time member of the armed forces of any country; (4) the date you fail to make any required contribution on behalf of your Dependent(s); or (5) the date your Dependent no longer meets the Plan's definition of Dependent.

Certificates of Coverage

Certificates of coverage are written documents provided by this Plan (or another source that offers health care coverage) to show the type of coverage a person had (e.g., employee only, employee plus spouse, etc.) and how long the coverage lasted. Under Federal law, most group health

plans must provide these certificates automatically when a person's coverage terminates, beginning in June 1997. However, if a plan does not give you a certificate, you have the right to request one. Certificates apply both to employees and to dependents.

One of the goals of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was to make it easier for people changing jobs to keep health insurance, regardless of their health status. The primary purpose of the certificates is to show the amount of "Creditable Coverage" that you had under a prior group plan or other health insurance coverage, because this can reduce or eliminate the length of time that any pre-existing condition clause in a new plan otherwise might apply to you. Creditable Coverage and how it affects pre-existing condition restrictions are explained in more detail under the Pre-Existing Conditions Limitation provision of this Plan.

The Plan will automatically give you a certificate after you lose coverage (whether regular coverage or COBRA continuation coverage) under the Plan, and will make reasonable efforts to provide on the certificate the names of your Dependents who were also covered. The Plan will provide automatic certificates for your Dependents when it has reason to know that they are no longer covered.

In addition, the Plan will provide a certificate for you (or your Dependents) upon request if you make the request within two years (24 months) after your coverage terminates. The Plan Administrator can give you forms to make such a request.

In accordance with Federal law, the Certificate of Coverage will only show your coverage under this Plan on or after July 1, 1996. See the Plan Administrator for information about confirming any coverage you had before that date.

Continuation of Coverage

Coverage under this Plan will continue for a terminated employee and his Dependents only as specified by the Plan, any collective bargaining agreement, or any applicable law, subject to the payment of any required contribution. Active Employee status does not extend beyond the last day of Active Employment for a terminated employee. Salary continuation between the end of one school year and the beginning of another school year does not extend the period of Active Employment for a terminated employee.

Right to Continue Benefits under the Family and Medical Leave Act of 1993 (P.L. 103-3)

This Plan intends to comply with the Family and Medical Leave Act of 1993 (FMLA) regarding the maintenance of Health Benefits during any period that an eligible employee takes a reasonable leave of absence as specified under the FMLA for medical reasons, for the birth or adoption of a child, or for the care of a child, spouse or parent who has a serious health condition. This Plan will also permit an employee who is a spouse,

son, daughter, parent, or next of kin to take a leave of absence to care for a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness, This Plan will also permit an employee to take FMLA leave for any qualifying exigency (as the Secretary of Labor shall, by regulation, determine) arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. By its express terms, this provision is not effective unless the Secretary of Labor issues final regulations defining "any qualifying exigency." In such situations, the FMLA allows an eligible employee to maintain "group health plan" coverage at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of such leave. Employee eligibility requirements, the obligations of the employer and employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA. Any Plan provision(s) which conflict with the FMLA are superseded by the FMLA to the extent such provision(s) conflict with the FMLA. An employee with questions concerning any rights and/or obligations under the FMLA should review the posted notice on the FMLA at his place of employment or contact his employer or Plan Administrator.

Right to Continue Benefits under Federal Law

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The following is a summary of the federal law.

COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description *or* get a copy of the Plan Document from the Plan Administrator. The name, address and telephone number of the Plan Administrator are listed in the Plan Information section of your Plan's Summary Plan Description booklet.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for

coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

If you have any questions concerning the information in this notice or your rights to continuation coverage, you may contact your Employer, the Plan Administrator, or the Claims Administrator, HealthSmart Benefit Solutions, Inc., at (330) 576-9000 or at the address listed below:

HealthSmart Benefit Solutions, Inc.
3320 West Market Street, Suite 100
Fairlawn, Ohio 44333-3306

COBRA Continuation Coverage. COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

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

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;

(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
(5) The parents become divorced or legally separated;
(6) The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs in order to be eligible to elect continuation coverage. The name, address and telephone number of the Plan Administrator are listed in the Plan Information section of your Plan's Summary Plan Description booklet.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. **A qualified beneficiary will have 60 days from the later of the date such person would lose coverage or the date the Election Notice is provided by the Plan Administrator to elect continuation coverage.** For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage 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 at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and**

before the end of the 18-month period of COBRA continuation coverage in order to be eligible for the extension of continuation coverage. The name, address and telephone number of the Plan Administrator are listed in the Plan Information section of your Plan's Summary Plan Description booklet. If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must give notice of the fact within 30 days of the Social Security Administration's determination.

Second qualifying event extension for 18-month period of continuation coverage. If your family experiences another qualifying event that would have triggered a loss of coverage under the Plan while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event in order to be eligible for the extension of continuation coverage. The name, address and telephone number of the Plan Administrator are listed in the Plan Information section of your Plan's Summary Plan Description booklet.**

How can you elect continuation coverage? Individuals eligible for continuation coverage will be notified of their rights and will be given an Election Form which must be completed and returned in order to purchase coverage. Each qualified beneficiary has an independent right to elect continuation coverage. **A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.**

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

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of the continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period.

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Although periodic payments are due on specified dates, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

If You Have Questions. For additional information you may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at ***www.dol.gov/ebsa***.

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

Rights under the Uniformed Services Employment and Reemployment Rights Act (P.L. 103-353)

This Plan intends to comply with the Uniformed Services Employment and Reemployment Rights Act (USERRA), as amended from time to time, which gives continuation of coverage rights to employees going on military leave. USERRA also specifies certain rights regarding reinstatement of coverage for employees returning from a military leave. All employers are subject to the law, including small employers and state and local governments.

If the Plan terminates an employee's coverage because of an absence due to military service, the employee may elect to continue and pay for coverage under the Plan for up to 24 months after the absence begins (or for any other time period required by USERRA) or for the period of service, whichever period is shorter. The employee cannot be required to pay more than 102% of the full cost for the coverage. If the military service lasts for 30 or fewer days, the employee cannot be required to pay more than the normal employee share of any cost of coverage. Continuation coverage cannot be discontinued by an employer because activated military personnel receive health coverage as active duty members of the armed forces and their family members are eligible to receive coverage under the Civilian Health and Medical Program of the Uniformed Services.

Employees are required to give the employer advance notice of their obligation or intention to perform either voluntary or involuntary service in the services, unless advance notice is impossible or unreasonable due to "military necessity".

In general, under USERRA reemployed service members are entitled to the seniority and all rights and benefits based on seniority that they would have attained had they remained continuously employed. If the employee does not continue coverage under the Plan while on leave, exclusions or waiting periods may not be imposed prior to reinstating the employee's coverage upon reemployment if coverage would have been provided to a person had the person not been absent for military service. However, an exception applies to disabilities determined by the Veterans Administration to be service-connected.

Due to the comprehensive nature of the USERRA law, not all of its requirements can be listed here. Under USERRA, the Department of Labor, through the Veterans Employment and Training Service (VETS), must provide assistance to all persons having claims under USERRA. An employee with questions concerning any rights or obligations under USERRA may also contact his employer or Plan Administrator.

Employee Benefits Provisions of the Omnibus Budget Reconciliation Act of 1993 P.L. 103-66 (OBRA 1993)

This Plan intends to comply with the Employee Benefits Related Provisions of OBRA 1993, as amended from time to time, as summarized below:

(1) Group health plans must honor qualified medical child support orders.

OBRA 1993 requires employer-sponsored group health plans to recognize "qualified medical child support orders" by providing benefits for participants' children in accordance with such orders.

A **"medical child support order"** (MCSO) is any court judgment decree or order (including approval of a domestic relations settlement agreement) that (1) provides for child support related to health benefits with respect to the child of a group health plan participant, or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law, or (2) enforces a state medical child support law enacted under the Social Security Act with respect to a group health plan.

A **"qualified medical child support order"** (QMCSO) is one that (1) either creates or recognizes the right of an alternate recipient - a participant's child who is recognized under the order as having a right to be enrolled under the plan - or assigns to the alternate recipient the right to receive benefits for which a participant or other beneficiary is entitled under the group health plan, and (2) includes the name and last known address of the participant and of each alternate recipient, a description of the type of coverage to be provided or the manner in which such coverage is to be determined, the period for which coverage must be provided, and each plan to which the order applies.

Notification and determination requirements. To facilitate determination, your group health plan has established reasonable written procedures (available upon request) for determining whether MCSOs are QMCSOs and for administering the provision of benefits under QMCSOs.

When a plan administrator receives an MCSO, it will promptly notify the participant and each alternate recipient that it has received the order and must inform them of the plan's procedures for determining if the order is a QMCSO. The administrator will then - within a reasonable time - determine whether the MCSO is qualified and notify the participant and any alternate recipients of the determination. The Plan will pay benefits in line with the administrator's determination.

Direct medical expense reimbursement to alternate payees. A group health plan must permit an alternate recipient to designate a representative to receive any required communications. Any payment for benefits made by a group health plan under a QMCSO

to reimburse an alternate recipient's out-of-pocket medical expenses paid by the recipient, or by his custodial parent or legal guardian, must be made to the recipient, custodial parent, or guardian.

(2) States to enact laws requiring issuance of medical child support orders.

As a condition of receiving federal assistance for state Medicaid programs, OBRA 1993 requires states to enact a series of laws "relating to medical child support."

States must have laws that specifically prohibit a group health plan from denying enrollment of a child under the health coverage of the child's parent on the ground that (1) the child was born out of wedlock, (2) the child is not claimed as a dependent on the parent's federal income tax return, or (3) the child does not reside with the parent or in the insurer's service area.

Whenever a court or administrative order requires a parent to provide health coverage for a child and that parent is eligible for family coverage through an employer doing business in the state, states must have laws requiring the employer to enroll the child under the family coverage and withhold from the employee's compensation any employee share of health coverage contributions or premiums.

In any case in which a child has health coverage through the insurer of a noncustodial parent, states must have laws requiring insurers to provide all information to the custodial parent that is needed in order for the child to obtain benefits through such coverage, to permit the custodial parent (or the provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent, and to make payments on such claims directly to the custodial parent, provider, or state Medicaid agency.

(3) States' recovery of Medicaid payments from private health plans.

OBRA 1993 both amends the Social Security Act to require states to enact laws to ensure that Medicaid will be only the secondary payer of claims and amends ERISA to alter the preemption provision accordingly and to require plans to adopt parallel coordination provisions.

Substantive plan requirements. OBRA 1993 requires that benefit payments on behalf of a participant who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the participant.

A group health plan may not take into account with respect to plan enrollment or benefits that an individual qualifies for medical assistance under a state Medicaid plan. Also, group health plans must honor any subrogation rights that a state may have gained by virtue of the state's having paid Medicare benefits for which the private plan has a legal liability for covering.

(4) Health plan coverage of adopted children.

OBRA 1993 amends ERISA to require health plan coverage for adopted children who are under age 18 as of the date of adoption or placement for adoption.

If a group health plan provides coverage for dependent children of participants or beneficiaries, (1) it must extend participation and benefits under the same terms and conditions for the adopted children of participants or beneficiaries as for natural children, regardless of whether the adoption has become final and (2) a plan may not restrict the benefits of an adopted child solely on the basis of a preexisting condition of the child at the time the child would otherwise be eligible for coverage, so long as the adoption (or placement for adoption) occurs while the participant or beneficiary is eligible for participation in the plan.

(5) Child immunization anti-cutback provision.

A group health plan may not reduce benefits provided as of May 1, 1993, for pediatric vaccines.

IV
DESCRIPTION OF COMPREHENSIVE MAJOR MEDICAL EXPENSE COVERAGE

The Plan will pay, after satisfaction of the specified Deductible Amount, the Benefit Percentage indicated in the Schedule of Benefits, subject to the specified maximums.

Benefit Limits and Maximums

Benefits payable under Comprehensive Major Medical Expense Coverage are subject to the Benefit Limits and Maximums specified in the Schedule of Benefits and to all exclusions and limitations of this Plan.

Calendar Year Deductible Amount

The Individual Calendar Year Deductible Amount is the amount of Eligible Expenses as shown in the Schedule of Benefits which must be incurred by a Covered Person during each Calendar Year, for which no benefits are payable under the Plan.

When two or more Covered Persons in a family incur Eligible Expenses during the same Calendar Year, and the total combined expenses used toward satisfying their Individual Deductibles are at least equal to the Family Deductible shown in the Schedule of Benefits, no further Deductible Amounts are required for that family for the remainder of the Calendar Year.

If, during the last three months of a Calendar Year, a Covered Person incurs Major Medical expenses which are applied toward the Deductible Amount, these expenses will also be applied to the Deductible Amount for the next Calendar Year.

Common Accident Deductible Limit

If two or more Covered Persons in the same family are injured in a common accident, the Deductible Amount applicable in the Calendar Year of the common accident will be limited to a single Deductible Amount for the Calendar Year for Eligible Expenses related to that accident which are incurred by all family members.

Benefit Percentage

The Plan will pay the Benefit Percentage indicated in the Schedule of Benefits for Eligible Expenses incurred by a Covered Person after the satisfaction of any required Deductible Amount.

Out-of-Pocket Maximum

Out-of-Pocket Expenses means those Eligible Expenses, which are incurred by a Covered Person in a Calendar Year, for which no payment is made by the Plan because of any Copayments, Deductible Amounts, and Coinsurance that results from the Benefit Percentage rate at which benefits are payable by the Plan.

When, during the Calendar Year, Out-of-Pocket Expenses of a Covered Person equal the Individual Out-of-Pocket Maximum shown in the Schedule of Benefits,

Eligible Expenses incurred by that Covered Person during the rest of that Calendar Year will be payable at a 100% Benefit Percentage.

When, during the Calendar Year, Out-of-Pocket Expenses of covered members of a family combined equal the Family Out-of-Pocket Maximum shown in the Schedule of Benefits, Eligible Expenses incurred by covered members of that family during the rest of that Calendar Year will be payable at a 100% Benefit Percentage

The Out-of-Pocket Maximum does not include any of the following, and once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:

(1) Any charges for non-covered health services.
(2) Charges that exceed Eligible Expenses.
(3) Contributions a Covered Person pays toward the cost of coverage.

The Out-of-Pocket Maximum under the Comprehensive Major Medical Expense Coverage portion of this Plan is separate from, and will not be used to satisfy any Copayments, Deductible or Out-of-Pocket Maximum under the Prescription Drug Expense Coverage portion of this Plan, or vice versa. After a Covered Person has satisfied the Comprehensive Major Medical Expense Coverage Individual or Family Out-of-Pocket Maximum, the Plan will pay 100% of the cost of Medically Necessary Eligible Expenses that are incurred under the Comprehensive Major Medical Expense Coverage for the remainder of the Calendar Year.

The Out-of-Pocket Maximum under the Prescription Drug Expense Coverage portion of this Plan is separate from, and will not be used to satisfy any Copayments, Deductible or Out-of-Pocket Maximum under the Comprehensive Major Medical Expense Coverage portion of this Plan, or vice versa. After a Covered Person has satisfied the Prescription Drug Expense Coverage Individual or Family Out-of-Pocket Maximum, the Plan will pay 100% of the cost of Medically Necessary Eligible Expenses that are incurred under the Prescription Drug Expense Coverage for the remainder of the Calendar Year.

Eligible Comprehensive Major Medical Expenses

(1) Charges made by a Hospital for Room and Board, payable at the Semi-Private Charge billed by the Hospital in which the patient is confined. The Plan will also pay charges for Special Care Units and Hospital Miscellaneous Services.
(2) Charges made by a Physician for medical care or treatment.

(3) Charges made by a Physician for surgical procedures performed on an Inpatient or Outpatient basis at the Reasonable and Customary Charge as determined and administered by the Plan.

(4) Charges made by a Physician for a second surgical opinion, limited to the examination, consultation, and any additional diagnostic tests required to properly evaluate the Medical Necessity of surgery. The second opinion must be secured from a board certified specialist in the field for which the patient is contemplating surgery, and must not be part of the same medical or surgical group as the first opinion surgeon. If the second surgical opinion does not confirm the need for surgery, a third opinion may be obtained and will be paid the same as the second surgical opinion.

(5) Charges made by a Registered Nurse (R.N.), or a Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.) for private duty nursing in the patient's home, Hospital or elsewhere, provided such services are certified as Medically Necessary by the attending Physician. Benefits are payable as specified in the Schedule of Benefits.

(6) Charges for the following medical services or supplies that are ordered by a Physician:

(a) Anesthesia, including the charge for administration.
(b) Oxygen, including the rental of equipment required for its administration.
(c) X-ray examination, microscopic and laboratory tests and other diagnostic services.
(d) Routine pap tests, mammograms and prostate examinations (including office visit), payable as specified under the "evidence-based preventive services benefit" of the Patient Protection and Affordable Care Act.
(e) Radiation Therapy, chemotherapy, radium and radioactive isotope treatments.
(f) Blood and blood plasma (if not replaced) and other fluids to be injected into the circulatory system.
(g) Medical supplies including but not limited to braces, crutches, casts, splints, trusses, surgical dressings, and ostomy supplies.
(h) The initial prostheses, orthopedic appliance, artificial limb or eyes, or a replacement if occasioned by the natural growth and development of a Covered Person or otherwise deemed Medically Necessary.
(i) The rental or purchase, whichever is the least expensive, of durable medical equipment, including wheelchairs, hospital beds, and other hospital-type medical equipment used exclusively for therapeutic treatment.
(j) Speech therapy provided by a qualified speech therapist for the purpose of correcting speech loss or damage which follows surgery to correct a birth defect or which is due to an Injury or Illness (other than a functional nerve disorder), or surgery due to such Injury or Illness.
(k) Physical therapy provided by a licensed physical therapist.
(l) Occupational therapy provided by a licensed occupational therapist when rendered as part of a physical medicine and rehabilitative program to improve functional impairments. Benefits are not payable for diversional, recreational or vocational therapies (such as hobbies, arts and crafts).
(m) Contraceptive injections, contraceptive implants, intrauterine devices, and other Eligible Expense for pregnancy related conditions on the same basis as any other Illness (to include contraceptive treatments that may be available in the future).
(n) Allergy serum and injections.

(7) Charges for emergency transportation to the nearest Hospital or other covered medical facility (including transfer between Hospitals) where necessary care and treatment can be provided. Such transportation must be certified as Medically Necessary by a Physician and must be furnished by a professional ambulance service.

(8) Maternity expenses incurred by an employee or Dependent.

(9) Charges for therapeutic (Medically Necessary) and elective abortions.

(10) Charges for routine newborn nursery care, the initial in-Hospital physical examinations and circumcision of newborn Dependent child.

(11) Charges for elective sterilization procedures.

(12) Charges for well child care (routine examinations, inoculations, x-ray and laboratory tests), including review of the child's emotional status, for a Dependent child, payable as specified under the "evidence-based preventive services benefit" of the Patient Protection and Affordable Care Act.

(13) Charges for "evidence-based preventive services" items and services as defined under the Patient Protection and Affordable Care Act, payable as specified in the Schedule of Benefits.

(14) Charges made by a Skilled Nursing Facility, provided the Covered Person's attending Physician certifies that twenty-four hour nursing care is Medically Necessary. Benefits are payable as specified in the Schedule of Benefits. Eligible Expenses will include:

(a) the daily Room and Board charge, not to exceed the facility's Semi-Private Room Charge; and
(b) the facility's other charges for medical care;

for a Period of Skilled Nursing Facility Confinement.

A Period of Skilled Nursing Facility Confinement means Inpatient Confinement of a Covered Person in a Skilled Nursing Facility provided:

(a) the Confinement starts within 14 days after discharge from the Hospital;
(b) the Hospital Confinement lasts at least 3 days in a row; and
(c) the Skilled Nursing Facility Confinement is due to the same or related Illness or Injury that caused the Hospital Confinement.

(15) Charges made by a Home Health Care Agency for the following medical services and supplies provided under the terms of a Home Health Care Plan for the Covered Person named in that plan:

(a) part-time or intermittent nursing care by or under the supervision of a Registered Nurse (R.N.);
(b) part-time or intermittent services of a Home Health Aide;
(c) physical, occupational or speech therapy (if not excluded under the Plan); and

(d) medical supplies; drugs and medicines prescribed by a Physician; and laboratory services; but only to the extent that such charges would have been considered Eligible Expenses if the Covered Person had been confined in a Hospital.

Benefits are not payable for charges made by a Home Health Care Agency for:

(a) home health care visits which exceed the Home Health Care maximum, if any, specified in the Schedule of Benefits. (Each visit by an employee of a Home Health Care Agency will be considered one home health care visit and each 4 hours of Home Health Aide services will be considered one home health care visit);
(b) more than two hours of nursing care in any twenty-four hour period;
(c) care or treatment which is not stated in the Home Health Care Plan;
(d) the services of a person who is a member of your family or your Dependent's family or who normally resides in your home or your Dependent's home;
(e) a period when a Covered Person is not under the continuing care of a Physician; or
(f) Custodial Care.

(16) Charges for Hospice Care provided to a terminally ill Covered Person whose life expectancy is 6 months or less as certified in writing by the attending Physician before the date the initial Hospice Care begins.

Hospice Care includes the following services which are provided by an Inpatient Hospice Facility or through a Hospice Care Agency as part of a Hospice Care Plan:

(a) Room and Board for Confinement in a Hospice Facility;
(b) services and supplies furnished by the Hospice Facility while the patient is confined therein;
(c) part-time nursing care by or under the supervision of a registered nurse (R.N.);
(d) Home Health Aide services;
(e) dietary services; and
(f) counseling services by a licensed social worker or a licensed pastoral counselor.

Hospice Care does not include charges:

(a) for Hospice Care provided in excess of the Hospice Care maximum, if any, specified in the Schedule of Benefits;
(b) for services provided by volunteers or persons who regularly do not charge for their services;
(c) for predeath counseling which is not provided by or through the Hospice program of care for the sole purpose of adjustment to the terminally ill Covered Person's death;

(d) for services provided by homemakers, caretakers and the like;
(e) for funeral services and arrangements;
(f) for legal or financial services or counseling;
(g) for curative treatment or services; or
(h) for Hospice Care services not made or recommended by the Covered Person's attending Physician or a Hospice program Physician.

If the patient lives beyond his life expectancy and exceeds the Hospice Care maximum, if any, specified in the Schedule of Benefits, he may be eligible for additional benefits, provided the attending Physician submits, in writing, recertification of the Covered Person's prognosis of six months or less to live.

(17) Charges for services and supplies received in connection with human tissue and organ transplant procedures (kidney, bone marrow, heart, heart/lung, lung, liver, pancreas and cornea) subject to the following conditions:

(a) A second surgical opinion must be obtained prior to undergoing any transplant procedure listed above. The mandatory second opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure.

The second opinion must be rendered by a board-certified surgeon who is not affiliated in any way with the Physician or the surgeon who rendered the first surgical opinion. The surgeon who gives the second surgical opinion may not perform the surgery.

(b) If the donor is a Covered Person under this Plan, his Eligible Expenses will be covered if donor benefits are not provided under the recipient's plan.

(c) If the recipient is covered under this Plan, his Eligible Expenses will be covered.

(d) If the recipient is a Covered Person but the donor is not, the donor's Eligible Expenses are covered under this Plan if his expenses are not payable under any other plan.

(e) If both the donor and the recipient are covered under this Plan, Eligible Expenses incurred by each person will be considered separately.

(f) The Reasonable and Customary cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and Hospital's charge for storage or transportation of the organ, will be considered an Eligible Expense.

All other human organ/tissue transplants or replacement procedures will be covered the same as any other illness.

(18) This Plan intends to comply with Section 10103(c) of the Patient Protection and Affordable Care Act (PPACA), as amended, which imposes requirements on group health plans to provide for coverage of routine patient costs associated with approved clinical trials as summarized in this provision.

The Plan pays for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

(a) cancer;
(b) cardiovascular disease (cardiac/stroke);
(c) surgical musculoskeletal disorders of the spine, hip, and knees;
(d) a clinical trial or study approved under the September 19, 2000, Medicare National Coverage Decision regarding clinical trials, as amended; and
(e) other diseases or disorders for which a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying Clinical Trial. Benefits are available only when the Covered Person is clinically eligible for participation in the Clinical Trial as defined by the researcher. Benefits are not available for preventive Clinical Trials.

Routine patient care costs for Clinical Trials include:

(a) Covered Health Services for which Benefits are typically provided by the Plan absent a Clinical Trial;
(b) Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
(c) Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for Clinical Trials do not include:

(a) the Experimental or Investigational Service or item.
(b) items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
(c) items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying Clinical Trial, a Clinical Trial must meet all of the following criteria:

(a) be sponsored and provided by a cancer center that has been designated by the National Cancer Institute (NCI) as

a Clinical Cancer Center or Comprehensive Cancer Center or be sponsored by any of the following:

National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
Centers for Disease Control and Prevention (CDC);
Agency for Healthcare Research and Quality (AHRQ);
Centers for Medicare and Medicaid Services (CMS);
Department of Defense (DOD); or
Veterans Administration (VA).

(b) have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial.; and
(c) the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Benefits include Covered Health Services provided in accordance with the Covered Person's treating Physician who is providing Covered Health Services after determining that participating in the Clinical Trial has the potential to provide a therapeutic health benefit to the Covered Person and meets all of the following criteria:

(a) the clinical trial or study is approved under the September 19, 2000 Medicare National Coverage Decision regarding Clinical Trials, as amended;
(b) the patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner;
(c) prior to participation in a Clinical Trial or study, the Covered Person has signed a statement of consent indicating that the Covered Person has been informed of the procedure to be undertaken, alternative methods of treatment, and the general nature and extent of the risks associated with participation in the Clinical Trial or study; and
(d) the Covered Person suffers from a condition that is disabling, progressive, or life threatening.

Coverage does not include:

(a) any portion of the Clinical Trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;
(b) coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
(c) extraneous expenses related to participation in the Clinical Trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur;

(d) any item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;
(e) cost for the management of research relating to the Clinical Trial or study; and
(f) health care services that, except for the fact that they are being provided in a Clinical Trial, are otherwise specifically excluded from coverage under the Plan.

Exclusions Applicable to Comprehensive Major Medical Expense Coverage

(1) Charges incurred after the date of individual termination of coverage under this Plan.

(2) Charges not Medically Necessary for the diagnosis or treatment of an Illness or Injury except as specifically included as Eligible Expenses.

(3) Charges in excess of the Reasonable and Customary (R&C) amount.

(4) Charges not prescribed or recommended by a Physician.

(5) Charges for services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable him to live outside of an institution.

(6) Charges for Custodial Care.

(7) Charges for personal convenience items including, but not limited to, TV and telephone, guest trays, guest beds and reading material.

(8) Charges directly or indirectly related to infertility treatment, including invitro fertilization or embryo transplant procedures, surrogate parenting procedures, artificial insemination, fertility drugs or other infertility treatment.

(9) Charges for vaccinations, inoculations and preventive shots, unless specifically included as Eligible Expenses.

(10) Charges for routine pap tests, mammograms or prostate examinations, unless specifically included as Eligible Expenses.

(11) Charges for hearing aids, eyeglasses, contact lenses, and the fitting thereof, or eye examinations, unless specifically included as Eligible Expenses.

(12) Charges for cosmetic surgery except to correct a congenital defect in a newborn child, to repair the effects of an Injury or to perform reconstructive breast surgery on an individual due to mastectomy.

(13) Charges for the treatment of corns, calluses or toenails, unless the charges are for the removal of nail roots or in conjunction with the treatment of a metabolic or peripheral vascular disease.

(14) Charges for orthopedic shoes or other supportive appliances for the feet, unless specifically included as Eligible Expenses.

(15) Charges for any care or treatment of teeth, gums, alveolar process, gingival tissues or Temporomandibular Joint (TMJ) Disturbances (including the prevention or correction of teeth irregularities and malocclusion of the jaw by wire appliances, braces or other mechanical aids) unless such charges are for the professional services of a Physician or qualified oral surgeon in rendering any of the following treatments:

(a) treatment to repair the effects of an Injury to sound natural teeth;
(b) treatment for the excision of bony impacted, unerupted teeth, or for the excision of a tumor or cyst, or the incision and drainage of an abscess or cyst; or
(c) surgical treatment of Temporomandibular Joint (TMJ) Disturbances.

(16) Charges for transportation except as specifically included as Eligible Expenses.

(17) Charges for drugs unless specifically included as Eligible Expenses.

(18) Charges for sterilization reversal, or any complications thereof.

(19) Charges for sexual conversion surgery, or any other services related to gender reassignment or disturbances of gender identification, or any complications thereof.

(20) Charges for bio-feedback training.

(21) Charges for marital counseling.

(22) Charges for hair replacement, transplant, removal or hairgrowth stimulants.

(23) Charges for treatment of obesity, except when a diagnosis of morbid obesity is determined.

(24) Charges for services and supplies provided on a Friday, Saturday or Sunday for a non-emergency Hospital admission occurring on a Friday, Saturday or Sunday, unless surgery is scheduled the following day.

(25) Charges for diagnostic x-ray exams and laboratory tests, ECG's, EKG's, and other diagnostic tests not related to a specific Injury or Illness or a definite set of symptoms.

(26) Charges for a Hospital admission when the primary reason for admission is to perform diagnostic x-ray exams and other diagnostic tests which could have been performed on an Outpatient basis unless certified as Medically Necessary by the attending Physician.

(27) Charges for routine physical examinations and health check-ups, unless specifically included as Eligible Expenses.

(28) Charges for speech therapy, except as specifically included as Eligible Expenses.

(29) Charges incurred in connection with any treatment, therapy, teaching technique or program for remedial education or habilitative or rehabilitative training which is principally intended to overcome, ameliorate or compensate for any learning impairment whatsoever, regardless of whether such impairment is diagnosed as functional or organic, unless specifically included as Eligible Expenses.

(30) Charges for treatment of conditions related to attention deficit disorder, hyperkinetic syndromes, autism, behavioral problems or mental retardation.

(31) Charges for any surgical procedure for the correction of a visual refractive problem, including radial keratotomy.

(32) Charges for hearing or vision therapy and any related diagnostic testing, unless specifically included as Eligible Expenses.

(33) Charges for contraceptive drugs and devices, emergency contraceptives, vitamins, minerals or food supplements, unless specifically included as Eligible Expenses.

(34) Charges for the treatment of nicotine dependency.

(35) Charges for growth hormone drugs.

(36) Charges which exceed a specified maximum.

(37) Charges for which benefits are not payable according to the “General Exclusions” section.

V
DESCRIPTION OF PRESCRIPTION DRUG EXPENSE COVERAGE

Prescription Drug Expense Coverage benefits are payable if a Covered Person incurs an Eligible Expense for the filling of a covered Prescription by a licensed pharmacist. A Physician's prescription does not guarantee that a particular drug is a legend drug and covered under the Plan.

Copayment/Benefit Percentage

The Plan will pay the Benefit Percentage indicated in the Schedule of Benefits minus the Copayment or Deductible Amount, if any, indicated in the Schedule of Benefits.

Eligible Prescription Drug Expenses

The Plan will pay a benefit for Eligible Expenses incurred for the following covered prescription drugs or medicine issued by the written order of a Physician:

(1) Federal Legend Drug - A drug or medicine which carries on the label of the bottle or original package the statement, "Caution: Federal Law prohibits the dispensing without a prescription".
(2) State Restricted Drug - A drug or medicine which under applicable state law may only be dispensed upon the written prescription of a Physician.
(3) Compounded Medication - A drug or medicine mixture which has in it at least one Federal Legend Drug or State Restricted Drug.
(4) Insulin, insulin needles and syringes.
(5) Oral contraceptives, topical contraceptives, contraceptive implants, emergency contraceptives.
(6) Acne products (covered through age 21).

Eligible Preventive Care Prescription Expenses

Prescription Drug Expense Coverage benefits under this Plan include preventive care prescription benefits as required under the Patient Protection and Affordable Care Act (PPACA). Preventive care prescription benefits are payable at no cost to the Covered Person. Unless specifically noted otherwise, a Physician's prescription is required and generic-only limits may apply. Other mandated preventive care benefits are covered under the medical expense coverage section of this Plan. The preventive care prescription benefits of this Plan are intended to comply with the "evidence-based preventive services" requirements of the PPACA and Eligible Expenses include:

(1) FDA-approved contraceptive prescriptions.
(2) Aspirin for cardiovascular disease protection.
(3) Folic acid for women of child bearing age.
(4) Iron supplements.
(5) Smoking cessation.
(6) Fluoride supplementation for preschool aged child (topical products not included).
(7) Any other "evidence-based" preventive prescription benefits as determined by federal law.

Exclusions Applicable to Prescription Drug Expense Coverage

The following are excluded from coverage unless specifically listed as a benefit under Eligible Prescription Drug Expenses:

(1) Drugs procured without a Physician's prescription.
(2) Anti-obesity drugs.
(3) Non-Federal Legend Drugs.
(4) Fertility agents.
(5) Any drug or medication which, when taken or used in accordance with the directions of the prescribing Physician, is made available in sufficient quantity to provide more than a thirty-four day supply without the necessity for a refill.
(6) Drugs obtained after the termination date of coverage under the Plan.
(7) Drugs labeled "caution--limited by federal law to investigational use", or experimental drugs, even though a charge is made to the individual.
(8) Refilling of a prescription in excess of the number specified by the Physician, or any refill dispensed after one year from the order of a Physician.
(9) Supplies used in connection with diabetes for testing the sugar level.
(10) Allergy serum.

Retail and Mail Service Maintenance Medication Prescription Drug Benefit

This Retail and Mail Service Prescription Drug Benefit enables a Covered Person to order maintenance prescription drugs by mail in quantities up to a 90 day supply. The Covered Person will be required to pay a Copayment as shown in the Schedule of Benefits. Prescription drugs eligible under this Benefit will include only those drugs otherwise eligible under the Prescription Drug Expense Coverage.

VI
DESCRIPTION OF
DENTAL EXPENSE COVERAGE

Dental Expense Coverage benefits are payable after satisfaction of the Deductible Amount, at the Benefit Percentage indicated of the Reasonable and Customary Charge (R&C), subject to any specified Maximum.

Calendar Year Maximum

The total amount of Dental Expense Coverage benefits payable per Calendar Year for expenses incurred for Preventive, Basic Restorative and Major Restorative Services will not exceed the Calendar Year Maximum shown in the Schedule of Benefits.

Orthodontic Lifetime Maximum

Both employee and spouse are eligible for Orthodontic Services. Orthodontic Services are an Eligible Expense for a Dependent child under age nineteen only. The total amount of Dental Expense Coverage benefits payable for all expenses incurred during a Covered Person's lifetime for Orthodontic Services will not exceed the Orthodontic Lifetime Maximum shown in the Schedule of Benefits.

Calendar Year Deductible Amount

The Individual Calendar Year Deductible Amount is the amount of Eligible Expenses as shown in the Schedule of Benefits which must be incurred by a Covered Person during each Calendar Year, for which no benefits are payable under the Plan.

When three or more Covered Persons in a family incur Eligible Expenses during the same Calendar Year, and the total combined expenses used toward satisfying their Individual Deductibles are at least equal to the Family Deductible shown in the Schedule of Benefits, no further Deductible Amounts are required for the remainder of the Calendar Year.

If, during the last three months of a Calendar Year, a Covered Person incurs Dental expenses which are applied toward the Deductible Amount, these expenses will also be applied toward the Deductible Amount for the next Calendar Year.

Benefit Percentage

The Plan will pay the Benefit Percentage indicated in the Schedule of Benefits for Eligible Expenses incurred by a Covered Person after the satisfaction of any required Deductible Amount.

Eligible Dental Expenses

Preventive & Diagnostic Services

(1) Routine oral examinations (including diagnosis) twice per Calendar Year.

(2) Prophylaxis twice per Calendar Year.

(3) Dental X-rays:

(a) Supplementary bitewing x-rays twice per Calendar Year.
(b) Full mouth x-rays once in any period of 36 consecutive months.
(c) Other x-rays as required in connection with the diagnosis of a specific condition requiring treatment.

(4) Topical application of fluoride once per Calendar Year.

(5) Emergency treatment to relieve pain.

(6) Space maintainers (including installation and the fitting thereof).

Basic Restorative Services & Supplies

(1) Tests and laboratory examinations including bacteriologic cultures, pulp vitality tests and diagnostic casts (study models).

(2) Oral surgery, including necessary pre-operative treatment during Hospital Confinement and customary post-operative treatment furnished in connection with oral surgery.

(a) Extraction of one or more teeth, except when done in connection with or in preparation for orthodontic services;
(b) Alveoloplasty (surgical preparation of ridge for dentures) and tooth replantation; and
(c) Treatment of fractures and reduction of dislocation of the jaw, and other cutting procedures in the oral cavity, except periodontic and endodontic surgery.

(3) Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or fractured teeth.

(4) General anesthesia and the administration thereof when Medically Necessary and administered in connection with oral or dental surgery.

(5) Endodontic treatment including root canal therapy.

(6) The injection of antibiotic drugs and application of desensitizing medication by the attending Dentist or Physician.

(7) The repair or recementing of crowns, inlays, onlays, bridgework or dentures, or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, not to exceed one relining or rebasing in any period of 36 consecutive months.

Major Restorative Services & Supplies

(1) Gingivectomy and osseous surgery and treatment of periodontal and other diseases of the gums and tissues of the mouth.

(2) Inlays, onlays, gold fillings or crown restorations to restore diseased or fractured teeth, but only when the tooth, as a result of extensive caries or fracture cannot be restored to proper function with an amalgam, silicate, acrylic, synthetic porcelain or composite restoration.

(3) Initial installation of removable partial or complete denture.

(4) Initial installation of fixed partial denture (bridgework -- including inlays and crowns as abutments).

(5) Replacement of an existing removable partial or complete denture or fixed partial denture by a new removable or fixed partial denture, or the addition of teeth to an existing removable partial denture or to a fixed partial denture, but only if: (1) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing removable partial denture or fixed partial denture was installed (2) the existing removable denture or fixed partial denture cannot be made serviceable and, if such a denture was installed at least five years prior to its replacement, or (3) the existing denture is an immediate temporary denture which cannot be made permanent, and replacement by a permanent removable denture takes place within twelve months from the date of initial installation of the immediate temporary denture.

Orthodontic Services & Supplies

(1) Orthodontic procedures required for the correction of malposed teeth; i.e. procedures performed that involve the use of an active Orthodontic appliance and post-treatment retentive appliance for the treatment of malalignment of teeth and/or jaws which significantly interferes with their function. Related oral examinations, surgery and extractions are included.

(2) Charges for appliances necessary for treatment of Temporomandibular Joint Disturbances will be covered as Orthodontic Services, subject to the Orthodontic Lifetime Maximum indicated in the Schedule of Benefits.

Occlusal Guards

(1) Occlusal guards to prevent grinding of teeth or to relieve joint pain.

Exclusions Applicable To Dental Expense Coverage

(1) Procedures or services rendered or supplies furnished by other than a Dentist or another Physician acting within the scope of his license, except for charges for procedures performed by a licensed dental hygienist acting within the scope of his license and under the supervision and direction of a Dentist or another Physician.

(2) Procedures, services or supplies primarily for beautification, including charges for personalization or characterization of dentures.

(3) Facings on pontics or crowns posterior to the second bicuspid.

(4) Sealants or education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.

(5) Procedures, services or supplies which are not necessary, according to accepted standards of dental practice.

(6) Procedures, services or supplies which do not meet accepted standards of dental practice, including charges for procedures, services or supplies which are experimental in nature.

(7) Any spare, duplicate or replacement prosthetic device or any other duplicate dental appliance within five years of the insertion or placement of the original prosthetic device or dental appliance.

(8) Any adjustment or repair to a denture which is performed within six months of the installation of the denture.

(9) The replacement of lost, missing or stolen prosthetic device, or any other dental appliance.

(10) Implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants.

(11) Periodontal splinting of teeth except for treatment of trauma.

(12) Procedures, appliances or restorations to increase the vertical dimensions or restore or maintain occlusion or stabilize periodontally involved teeth except as specifically included as Eligible Expenses. Such procedures include but are not limited to, equilibration, periodontal splinting, restoration of tooth structure lost from wear, rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion.

(13) Drugs or medication, including prescriptions, other than injection of antibiotics and application of desensitizing medication by attending Dentist.

(14) Any dental service or supply which is payable under a separate benefit in this Plan, except to the extent that dental benefits payable under this section exceed those benefits payable under the other section of the Plan.

(15) Any dental services or supplies which are furnished prior to the effective date of coverage. In the case of prosthetic devices and crowns charges will not be covered if the impressions were taken before the date coverage commenced, even though the prosthetic device or crown is not installed until after the date coverage commenced.

(16) Charges incurred after the termination date of coverage under this Plan.

(17) Orthodontic services and supplies incurred by a Dependent child age nineteen or older.

VII
DESCRIPTION OF
VISION EXPENSE COVERAGE

Benefits are payable after satisfaction of a Calendar Year Deductible Amount up to the amounts listed in the Schedule of Benefits, per Benefit Period specified, for Eligible Expenses incurred for the following professional fees and materials.

Eligible Vision Expenses

(1) Professional vision examination: This examination is a complete analysis of the vision functions, including the prescription of lenses where indicated. Benefits are payable as shown in the Schedule of Benefits.

(2) Lenses: Benefits are payable as shown in the Schedule of Benefits for lenses including single vision, bifocal, trifocal or more complex lenses, necessary for the patient's visual welfare. Covered materials include tints, plastic multi-focal lenses and oversized lenses.

(3) Frames: Benefits are payable as shown in the Schedule of Benefits.

(4) Contact lenses: Separate benefits are payable for <u>necessary</u> contact lenses and <u>cosmetic</u> contact lenses as shown in the Schedule of Benefits. Contact lenses are considered to be necessary only if one of the following conditions apply:

   (a) following cataract surgery;
   (b) to correct extreme visual acuity problems that cannot be corrected to at least 20/70 in one eye with spectacle lenses;
   (c) anisometropia; or
   (d) keratoconus.

   Benefits payable for contact lenses will be in lieu of all other frames and lenses benefits for the Benefit Period.

Exclusions Applicable To Vision Expense Coverage

(1) Orthoptics or vision training, subnormal vision aids, aniseikonic lenses, plano (non-prescription) lenses.

(2) Replacement of lenses and frames furnished under this program which are lost, stolen or broken, except at the normal intervals when services are otherwise available.

(3) Medical or surgical treatment of the eyes.

(4) Any eye examination required by an employer as a condition of employment; or any service or material provided by any other vision care plan or group benefit plan containing benefits for vision care.

(5) Any service or supply not listed in the Vision Schedule.

(6) Frames or lenses not needed to correct abnormal vision.

(7) Charges for vision expenses by other than a licensed provider.

(8) Charges for tinting of prescription sunglasses or for light-sensitive lenses in excess of the amount which would be covered for non-tinted lenses.

(9) Charges incurred after the termination date of coverage under this Plan.

VIII
GENERAL EXCLUSIONS APPLICABLE TO ALL COVERAGES UNDER THIS PLAN

(1) Charges incurred prior to the effective date of coverage under the Plan.

(2) Charges for care or treatment of an Injury or Illness arising out of or in the course of any employment or occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease Law, whether or not any coverage for such benefits is actually in force.

(3) Charges for treatment provided or furnished by the United States Government or the government of any other country. If this is inconsistent with any Federal Law this exclusion is inoperative.

(4) Charges related to the treatment of intentionally self-inflicted injuries, unless any such injury results from a medical condition (such as depression) as specified in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(5) Charges for care or treatment arising out of war, an act of war, declared or undeclared, or participation in a riot.

(6) Charges for the care or treatment as a result of being engaged in an illegal occupation or commission of or attempted commission of a felony or assault.

(7) Charges for care or treatment while a member of the armed forces of any state or country.

(8) Charges for which the Covered Person is not legally required to pay or which would not have been made if no coverage had existed.

(9) Charges for the completion of claim forms, medical reports or certifications required by the Plan.

(10) Charges which are not specifically included as Eligible Expenses.

(11) Charges for services rendered by a close relative of the Covered Person, including the immediate family or a person related by blood or marriage, or by a person who normally resides in the same household as the Covered Person.

(12) Charges for experimental treatment, procedures, drugs or research studies, or for any such service or supplies not considered legal in the United States.

(13) Charges for services or supplies which were provided more than 12 months prior to the date the charges are submitted to the Plan for payment.

IX
MISCELLANEOUS PROVISIONS

Coordination of Benefits (COB) Provision

This COB provision applies to This Plan when a Covered Person has health care coverage under more than one Plan. All of the health expense coverages provided by This Plan are subject to this provision.

(1) Definitions

For the purpose of this COB provision, the following definitions will apply:

Plan

Any arrangement of coverage which provides health benefits or services by means of:

(a) group, blanket or franchise coverage, whether insured or uninsured, including coverage provided through:

(i) HMO's and other prepayment group or individual plans;
(ii) automobile "no fault" and "fault" insurance, including uninsured/ underinsured motorist coverage and medical payment coverage;
(iii) hospital indemnity benefits of more than $100 per day;

(b) governmental programs, except:

(i) coverage provided under Title XVIII (Medicare) and Title XIX (Medicaid) of The Social Security Act of 1965, as amended; and
(ii) any plan when by law its benefits are excess to those of any private insurance plan or non-governmental plan;

(c) any coverage under:

(i) labor-management trusteed plans;
(ii) union welfare plans;
(iii) employer organization plans or employee benefit organization plans.

Plan does not mean:

(a) any type of school accident coverage, including college plans; or
(b) individual or family plans or contracts.

This Plan

The health expense benefits provided by the Employer.

Primary

A Plan which pays Allowable Expense without regard to the existence of any other Plans.

Secondary

Any Plan which is not considered the Primary Plan. When there are more than two Plans covering the same Covered Person, This Plan may be Primary as to one or more Plans and Secondary as to a different Plan or Plans.

(2) Order of Benefit Determination

A Plan will always be Primary and will pay its benefits first if the Plan has no COB provision or non-duplication provision with the same intent.

If, however, both Plans have a COB provision, the Primary and Secondary Plan will be determined according to the following rules:

(a) The benefits of a Plan which covers a person as an employee are determined before those of a Plan which covers a person as a Dependent.

(b) Covered Dependent Child / Parents **not** Separated or Divorced
The benefits of a Plan which covers a child as a Covered Dependent of a parent whose birthday falls earlier in the year are determined before those of a Plan of the parent whose birthday falls later in the year. A person's year of birth is not relevant in applying this rule.

(c) Covered Dependent Child / Parents Separated or Divorced
The benefits of a Plan which covers a child as a Covered Dependent of divorced or separated parents are determined in the following order:

(i) the benefits of the Plan of the parent who is the residential parent with legal custody of the child, or the equivalent as defined by the statute in the State in which you reside, are determined first;
(ii) the benefits of the Plan of the spouse of the parent who is the residential parent with legal custody of the child (the stepparent), or the equivalent as defined by the statute in the State in which you reside, are determined next;
(iii) the benefits of the Plan of the parent who is not the residential parent with legal custody, or the equivalent as defined by the statute in the State in which you reside, are determined last.

If, however, there is a court decree which would otherwise establish financial responsibility for the health care expenses of a child, then the benefits of the Plan which covers the parent with financial responsibility are determined before any other Plan.

(d) The benefits of a Plan which covers a person as an active employee (or a Dependent of such employee) are determined before the benefits of a Plan which covers such person as:

(i) a laid-off or retired employee;
(ii) the Dependent of a laid-off, retired or deceased employee; or
(iii) a COBRA beneficiary continuing coverage in accordance with federal law.

(e) If none of the above rules determine an order of benefits, then the benefits of a Plan which has covered the person for the longer period of time are determined before those of the Plan which has covered the person for the shorter period of time.

(f) The Covered Person's benefits under automobile "no fault" and "fault" insurance, including uninsured/underinsured motorist coverage, and medical payment coverage are determined before the benefits of this Plan.

(3) How Your Benefits Are Paid

(a) This Plan will determine which Plan is Primary and which Plan is Secondary. In order to obtain all benefits available, a Covered Person should file a claim under each Plan.

(b) This Plan will pay its benefits without regard to the existence of any other plan when it is Primary.

(c) When This Plan is Secondary it will pay a reduced benefit which, when added to the benefits paid by all other Plans, will not exceed 100% of the total Allowable Expense. Any benefits reduced during any Claim Determination Period because of this provision will be reduced proportionately. Only the reduced amount may be charged against any benefit limit of This Plan. No Plan will pay more than it would have paid in the absence of this COB provision.

Any benefit savings resulting from the application of the COB provision will be available for future claims. These savings may be applied toward additional Allowable Expenses that are not covered at 100% when the benefits have been coordinated among all Plans covering the Covered Person.

Effects of Medicare Provision

As required under the Tax Equity and Fiscal Responsibility Act (TEFRA), the Employer will offer to active employees and their covered Dependents, who are over age 65, the same benefits as are available to younger

employees and Dependents. The employee may choose to be covered under the Employer's group medical plan. If so, Medicare will then become the secondary provider of coverage.

Employers who provide medical care benefits under a "large group health plan" as defined in Section 5000 (b) of the Internal Revenue Code, will be the primary provider of coverage for disabled employees (except for End State Renal Disease beneficiaries) under age 65 and family members of such employees until the disability ends or age 65, provided the person entitled to Medicare is also eligible for and covered by the Employer's Plan.

Right Of Subrogation, Reimbursement And/Or Assignment

Subject to the provisions of this section, if the Plan pays any benefits to or on behalf of a covered person for injuries or death caused by another, the Plan shall, through subrogation, reimbursement and/or assignment recover the full value of benefits paid from the responsible third party, any liability or other insurance covering the third party, and/or any insurance company providing any medical payments, uninsured motorist insurance, underinsured motorist insurance, no-fault or school insurance coverages to the covered person, or from the covered person, his beneficiary or personal representative if the covered person, his beneficiary or personal representative is compensated for such injuries or death from any of the foregoing sources. The Plan shall be entitled to recover the full value of benefits paid from the first monies the covered person receives, or is entitled to receive, regardless of whether the covered person's claim is resolved by way of settlement, arbitration or civil judgment and regardless of whether such recovery is designated as economic or non-economic.

Unless otherwise first agreed to in writing by the Plan, there shall be no percentage reduction of repayment to the Plan because the covered person, his beneficiary or personal representative has received less than complete compensation for the injuries or death caused. Furthermore, unless otherwise first agreed to in writing by the Plan, the Plan shall not bear any costs, expenses or attorney fees incurred by the covered person, his beneficiary or personal representative in the prosecution of his claim for the injuries or death caused. In addition, if suit is necessary, the Plan can recover its costs of suit, including attorney's fees.

The covered person shall be entitled to continue to receive benefits under the Plan for claims incurred after the date the covered person obtains compensation either through a negotiated settlement, arbitration award, or court judgment only if the Plan (and its reinsurance carrier when necessary) approve the negotiated settlement or participated in the adversarial proceeding as a party-in-interest therein.

The covered person, his beneficiary or personal representative shall execute and deliver any documents as may be required by the Plan and do whatever else is necessary for the Plan to protect and exercise its subrogation, reimbursement and/or assignment rights and such person

shall do nothing to prejudice the Plan's rights hereunder. If the covered person, his beneficiary or personal representative does prejudice the Plan's rights hereunder, such prejudicial action, among other things, shall bar such persons from receiving benefits under the Plan.

The Plan shall have the right, at its option, to intervene in any litigation involving the covered person so as to assert its rights of subrogation, reimbursement and/or assignment under the Plan.

STANDARDS FOR PRIVACY OF PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

This provision is intended to bring the Jefferson Local Schools Health Benefit Plan (hereinafter "Plan") into compliance with the requirements of §164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and §164.504(f) is referred to as "the "504" provisions") by establishing the extent to which the Plan Sponsor will receive, use and/or disclose Protected Health Information. Accordingly, the Plan hereby includes the following:

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

Definitions. All terms defined in the HIPAA Privacy Rule shall have the meaning set forth therein, together with the following additional terms defined below:

(1) **Plan** means the Jefferson Local Schools Health Benefit Plan.

(2) **Plan Documents** mean the Plan's governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to the Health Plan Document of the Jefferson Local Schools Health Benefit Plan.

(3) **Plan Sponsor** means "plan sponsor" as defined at section 3(16)(B) of ERISA, 29 U.S.C §1002(16)(B). The Plan Sponsor is Jefferson Local Schools

The Plan's disclosure of Protected Health Information to the Plan Sponsor Requires a Certification of Compliance by Plan Sponsor. Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will disclose Protected Health Information to the Plan Sponsor or provide for or permit the disclosure of Protected Health Information to the Plan Sponsor by an entity servicing

the Plan, only if the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

(1) the Plan Documents state, or have been amended to state, the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the "504" provisions;
(2) the Plan Documents include, or have been amended to include, the Plan provisions set forth in this section; and
(3) the Plan Sponsor agrees to comply with the Plan provisions as stated in this section.

Permitted disclosure of individuals' Protected Health Information to the Plan Sponsor

(1) The Plan (and any business associate acting on behalf of the Plan), or any entity servicing the Plan, will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions. Such disclosure will be consistent with the provisions of this section.

(2) All disclosures of the Protected Health Information of the Plan's individuals by the Plan's business associate, or any entity servicing the Plan, will comply with the restrictions and requirements set forth in this section and in the "504" provisions.

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

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

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

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

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

Disclosure of individuals' Protected Health Information – Disclosure by the Plan Sponsor

(1) The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R §164.524.

(2) The Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R § 164.526.

(3) The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.

(4) The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

(5) The Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(6) The Plan Sponsor will ensure that the required adequate separation between the Plan and the Plan Sponsor, described herein, is established and maintained.

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

The Plan, or any entity servicing the Plan, may disclose summary health information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions, if the Plan Sponsor requests the summary health information for the purpose of:

(1) Obtaining premium bids for stop loss insurance coverage, or any other such coverage on behalf of the Plan; or
(2) Modifying, amending, or terminating the Plan.

The Plan, or any entity servicing the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

Required separation between the Plan and the Plan Sponsor

In accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may be given access to individuals' Protected Health Information received from the Plan or from an entity servicing the Plan.

(1) Analyst/Administrators
(2) Human Resources Personnel
(3) Information Technology Personnel
(4) Clerical Personnel
(5) Supervisors/Managers
(6) Quality Assurance Unit
(7) Service Personnel

This list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who may receive individuals' Protected Health Information relating to treatment, payment, health care operations of, or other matters pertaining to Plan administration functions that the Plan Sponsor provides for the Plan. The Plan Sponsor will maintain, separate from this document, a written list of the employees or workforce members under the control of the Plan Sponsor who are designated to receive Protected Health Information. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this section.

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

Security of Electronic Protected Health Information

The following provision is intended to bring this Plan into compliance with the requirements of 45 C.F.R § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 (the regulations are referred to herein as the **"HIPAA Security Standards"**), effective April 21, 2005 (April 21, 2006 for small health plans). The Plan Sponsor's added obligations with respect to the security of Electronic Protected Health Information are shown in italics:

Definitions

(1) **Electronic Protected Health Information** – The term " Electronic Protected Health Information" has the meaning set forth in 45 C.F.R § 160.103, and generally means protected health information that is transmitted or maintained in any electronic media.

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

Plan Sponsor Obligations Regarding Electronic Protected Health Information

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

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

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

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

(4) Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

(a) Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

(b) Plan Sponsor shall report to the Plan any other Security Incidents on a periodic basis or upon the Plan's request.

X
DEFINITIONS

The terms listed, if used, will have these meanings:

Active Contracted Employee

Members of the Jefferson Local Schools Board of Education or any full-time or part-time employees meeting the requirements of the negotiated collective bargaining agreement.

Acute Medical Condition

A condition or symptom which becomes so acute in nature and which is of such severity that it does in fact constitute an extremely hazardous medical condition which would result in jeopardy to the Covered Person's life or cause serious harm to his health if not treated immediately by a Physician.

Alcoholism or Drug Addiction Treatment Facility

A facility which: (1) operates within the scope of its license; (2) is engaged mainly in providing Inpatient services for the treatment of alcoholism or drug addiction in return for compensation; (3) provides 24 hour nursing services by or under the supervision of registered graduate nurses; and (4) maintains daily clinical records on each patient and has available at all times the services of a Physician under an established agreement.

In no event will this definition include an institution or any part of one which is a Skilled Nursing Facility, or any institution which is used primarily as: (1) a rest facility; (2) a nursing facility; (3) a facility for the aged; or (4) a place for custodial care.

Ambulatory Surgical Facility

A facility which: (1) operates within the scope of its license; (2) is engaged mainly in performing elective surgery; (3) admits and discharges each patient within a working day; (4) has a medical staff including Physicians and registered graduate nurses; (5) has permanent operating rooms, recovery rooms and equipment for emergency care; and (6) has transfer arrangements with a Hospital for patients requiring Hospital care following treatment in the Ambulatory Surgical Facility.

Benefit Percentage

That figure shown as a percentage in the Schedule of Benefits used to compute the amount of benefits payable for Eligible Expenses incurred by a Covered Person.

Calendar Year

A period of one year beginning with January 1 and ending December 31.

Confinement

The period of time during which a Covered Person is an Inpatient incurring a charge for Room and Board in a Hospital or other covered facility.

Contributory Coverage

Coverage for which the employee bears all or part of the cost.

Copayment

The portion of Eligible Expenses specified in the Schedule of Benefits which is payable by the Covered Person directly to a provider at the time of service or purchase.

Covered Person

An Eligible Person who enrolls, becomes covered and remains covered under this Plan, meeting the requirements as set forth in the "Eligibility for Coverage" section of this Plan.

Creditable Coverage

"Creditable Coverage" shall have that definition contained in ERISA Section 701 (c). Under this provision, Creditable Coverage generally includes periods of coverage under an individual or group health plan (including Medicare, Medicaid, governmental and church plans) that are not followed by a Significant Break in Coverage. Creditable Coverage does not include coverage for liability, dental, vision, specified disease and/or other supplemental-type benefits.

Custodial Care

Care comprised of services and supplies, including room and board and other institutional services, which is provided to an individual, whether Disabled or not, primarily to assist him in the activities of daily living.

Deductible Amount

The amount of Eligible Expenses as shown in the Schedule of Benefits, which must be incurred by a Covered Person during each Calendar Year or any other period specified before benefits become payable under the Plan.

Dentist

A person who is licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license. For the purpose of this definition, a Physician will be considered to be a dentist when he performs any covered dental service and is operating within the scope of his license.

Dependent

(1) Legal spouse of the employee;
(2) Dependent Child from birth to the end of the Calendar Year in which the Dependent child turns age twenty-six, in accordance with the provisions of the Patient Protection and Affordable Care Act;
(3) Dependent Child age nineteen and over who is mentally or physically handicapped. This incapacity must have started prior to the Dependent reaching the limiting age under the Plan. Proof of such incapacity and dependency must be furnished to the Plan within 31 days of the child's attainment of the limiting age under

the Plan. The Plan may require, at reasonable intervals, subsequent proof of the child's incapacity and dependency. The Plan reserves the right to have such Dependent examined by a Physician of the Plan's choice to determine the existence of such incapacity.

The term "Dependent Child" will include any natural child, step-child or adopted child, because of the relationship to the covered employee. Proof of the relationship may be required. The term "Dependent Child" will also include any other child for whom the employee has obtained legal guardianship.

A child for whom an employee is responsible by court decree for principal support or medical care is also included under this definition, or a child may be included as covered under this Plan as part of a Qualified Medical Child Support order as specified by Federal law.

Eligible Expense

Reasonable and Customary expense incurred by a Covered Person for services and supplies which are (1) recommended by a Physician; (2) Medically Necessary for the treatment of an Illness or Injury; and (3) provided after the effective date of coverage under this Plan.

Eligible Person

An employee and/or his Dependents are considered an Eligible Person when meeting the eligibility requirements as set forth in the "Eligibility for Coverage" section of this Plan.

Emergency Care Center

A public or private establishment with an organized staff of Physicians and with permanent facilities equipped mainly to provide immediate emergency accident care and non-acute medical care.

Employer

Jefferson Local Schools

Enrollment Date

The term "Enrollment Date" means the first day of coverage under this Plan or, if earlier, the beginning of any applicable Waiting Period under this Plan.

Expense Incurred

An expense is incurred when the service or the supply is actually provided.

Experimental/Investigative

Any treatment, procedure, facility, equipment, drug, device or supply which the Plan does not recognize as accepted medical practice or which did not have required governmental approval when received. Determination will be made by the Plan in its sole discretion and will be conclusive.

Freestanding Birth Center

An Outpatient facility which: (1) operates within the scope of its license; (2) maintains daily clinical records; (3) provides 24 hour nursing service by or under the supervision of registered graduate nurses or certified nurse midwives; (4) is staffed, equipped and operated to provide: (a) care for patients during uncomplicated pregnancy, delivery, and the immediate postpartum period; (b) care for infants born in the center who are normal or have abnormalities which do not impair function or threaten life; and (c) care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life pending transfer to a Hospital.

He, Him, His

Whenever the masculine pronoun is used in this booklet, it will include the feminine gender unless the context clearly indicates otherwise.

Home Health Aide

A person who provides care of a medical or therapeutic nature and reports to and is under the direct supervision of a Home Health Care Agency.

Home Health Care Agency

A public or private agency or organization, or part of one, that mainly provides skilled nursing and other therapeutic services. It must be legally qualified in the state or locality in which it operates. It must keep critical records on all patients. The services must be supervised by a Physician or registered nurse, and they must be based on policies set by associated professionals, which include at least one Physician and one registered nurse.

Home Health Care Plan

A plan for continued care and treatment of a Covered Person in his home. To qualify, the plan must be established in writing by a Physician who certifies that the Covered Person would require Confinement in a Hospital if he did not have the care and treatment stated in the plan. The Home Health Care Plan is subject to review and approval by an approved medical review organization.

Hospice Care Agency

An agency or organization that is licensed in the state in which it operates, has Hospice Care available 24 hours a day, 7 days a week and provides or arranges for Hospice Care services or supplies.

Hospice Care Plan

A plan that is supervised by a Physician and has a team consisting of: (1) a Physician who provides Hospice Care; (2) licensed nurses; (3) a licensed mental health specialist; and (4) a licensed social worker.

The Hospice Care Plan must be responsible for: (1) the patient's plan of care; (2) regular reviews of the patient's care; (3) informing the proper persons of any change in the patient's condition; and (4) complying with governmental regulations.

Hospice Facility

A facility which: (1) operates within the scope of its license; (2) is engaged mainly in providing palliative care for the terminally ill; (3) provides 24 hour nursing care by or under the supervision of a registered graduate nurse; (4) provides pre-death and bereavement counseling; (5) maintains daily clinical records on each patient; and (6) has available at all times the services of a Physician under an established agreement.

This definition does not include an institution or any part of one which is a Skilled Nursing Facility, or any institution which is used primarily as a nursing facility or facility for the aged.

Hospital

An institution which: (1) provides medical care and treatment of sick and injured persons on an Inpatient basis; (2) is properly licensed or permitted legally to operate as such; (3) has a Physician on call at all times; (4) has licensed graduate Registered Nurses on duty twenty-four hours a day; (5) maintains facilities for the diagnosis and treatment of Illness and for major surgery; and (6) meets the required standards of the Joint Commission on Accreditation of Hospitals.

The definition of Hospital may also include: (1) Alcoholism or Drug Addiction Treatment Facility; (2) Psychiatric Hospital; (3) Ambulatory Surgical Facility; (4) Freestanding Birth Center; (5) Hospice Facility; and (6) Rehabilitation Facility; provided the facility is licensed in the state in which the facility operates and is operating within the scope of its license.

The definition of Hospital does not include an institution or any part of one which is a Convalescent/Skilled Nursing Facility, or any institution which is used primarily as: (1) a rest facility; (2) a nursing facility; (3) a facility for the aged; or (4) a place for custodial care.

Hospital Miscellaneous Charges

Charges made by a Hospital for other than Room and Board and general nursing care including, but not limited to, amounts charged for necessary services, medicines, supplies or services for diagnosis or treatment of an Illness or Injury (except services of a Physician and drugs or supplies not consumed or used in the Hospital) while the Covered Person is confined as an Inpatient.

Illness

Any physical or mental sickness or disease which manifests treatable symptoms and which requires treatment of a Physician. This definition also includes pregnancy.

Injury

Trauma to the body requiring treatment by a Physician, caused by a sudden, unforeseen, unexpected external event.

Inpatient

A Covered Person who is a registered bed patient in a Hospital upon the recommendation of a Physician.

Late Enrollee

The term "Late Enrollee" means an individual who is enrolled for coverage after the initial eligibility date. Note, however, a Special Enrollee shall not be considered a Late Enrollee .

Leased Employee

An individual who is not paid through the Employer's payroll and who is typically compensated by a company (e.g., an employee leasing company or temporary agency) other than an Employer. Leased Employee includes (but is not limited to) individuals described in Internal Revenue Code Section 414 (n).

Medically Necessary

A service or supply which is necessary and appropriate for the diagnosis and treatment of an Illness or Injury based on generally accepted current medical practice.

The fact that any particular Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make that service Medically Necessary.

This definition does not include a service or supply if: (1) it is provided only as a convenience to the Covered Person; (2) it is not appropriate treatment for the Covered Person's diagnosis or symptoms; or (3) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

Medicare

Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as amended by Social Security Amendment of 1965 or as later amended.

Mental Illness

Mental disease or disorder or functional nervous disorder as recognized or defined by the American Psychiatric Association.

Non-Contributory Coverage

Coverage for which the employee does not pay any of the cost.

Outpatient

A Covered Person treated on a basis other than as a registered bed patient in a Hospital.

Physician

A legally qualified person acting within the scope of his license and holding the degree of: (1) Doctor of Medicine (M.D.); (2) Doctor of Osteopathy (D.O.); (3) Doctor of Dental Surgery (D.D.S.); (4) Doctor of Podiatry (D.P.M.); (5) Doctor of Chiropractic (D.C.); or (6) a Licensed Clinical Psychologist (Ph.D.).

The definition of Physician may be extended to include a: (1) Certified Nurse Midwife acting within the scope of his license, under the direction and supervision of a licensed Physician; (2) Licensed Physical Therapist (L.P.T.) or Licensed Speech Therapist (L.S.T.) when acting within the scope of their license and performing services ordered by a Doctor of Medicine or Doctor of Osteopathy; (3) Licensed Social Worker / Licensed Professional Clinical Counselor; (4) Licensed Nurse Practitioner; (5) Doctor of Optometry (O.D.); or (6) any other medical practitioner duly licensed under the governing authority to perform the services rendered and covered for benefits under the Plan.

Plan

Jefferson Local Schools Health Benefit Plan.

Podiatric Treatment

The actual services provided or recommended by a Podiatrist, including examinations, laboratory and x-rays, and treatment.

Reasonable and Customary Charges (R&C)

Charges made for medical services or supplies which are the amount normally charged by the provider for similar services and supplies, and do not exceed the amount of the Plan's established percentile of comparable services and supplies in the locality where the services or supplies are received. The percentile level may be modified at the Plan's discretion. Determination of whether or not a charge is R&C will be made by the Plan based on nationally obtained and recognized survey data.

If a Network Provider provides benefits, the R&C charge will be equal to the actual charge for the service or supply provided as agreed upon between the Preferred Provider Organization and the Plan.

Rehabilitation Facility

A legally operating institution or distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute Hospital and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, custodial care, ambulatory or part-time care services, or an institution which primarily provides treatment of mental disorders, chemical dependency or tuberculosis except if such facility is licensed, certified or approved as a Rehabilitation Facility for the

treatment of medical conditions or drug addiction or alcoholism in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Room and Board

Charges made by a Hospital for the cost of the room, general duty nursing care, and other services routinely provided to all Inpatients, not including Special Care Units.

Semi-Private Charge

The charge made by a Hospital for a room containing two (2) or more beds. This does not include charges for Special Care Units.

Significant Break in Coverage

The term "Significant Break in Coverage" means a period of 63 (or more) days without Creditable Coverage. Periods of no coverage during an HMO affiliation period or Waiting Period shall not be taken into account for purposes of determining whether a Significant Break in Coverage has occurred.

Skilled Nursing Facility

An institution or distinct part-thereof, operated pursuant to law and meeting all of the following requirements:

(1) maintains permanent and full-time facilities for bed care of 10 or more resident patients;
(2) has available at all times the services of a Physician;
(3) has a Registered Nurse (R.N.) or Physician on full-time duty in charge of patient care, and one or more Registered Nurses (R.N.'s), or Licensed Vocational Nurses (L.V.N.'s), or Licensed Practical Nurses (L.P.N.'s) on duty at all times;
(4) maintains a daily medical record for each patient;
(5) is primarily engaged in providing continuous skilled nursing care for sick or injured persons during the convalescent stage of their Illness or Injury;
(6) is operating lawfully as a Convalescent/Skilled Nursing Facility in the jurisdiction where it is located or meets the required standards of the Joint Commission on Accreditation of Hospitals; and
(7) has a written agreement with at least one other Hospital providing for the transfer of patients and medical information between the Hospital and Convalescent/Skilled Nursing Facility.

In no event, however, will Convalescent/Skilled Nursing Facility include an institution which is primarily: (1) a place for rest; (2) a place for the aged; (3) a place for drug addicts or alcoholics; (4) a place for the blind or deaf; (5) a place for the mentally ill or retarded; or (6) a hotel or similar place.

Special Care Unit

A Hospital unit which provides concentrated special equipment and highly skilled personnel for the care of critically ill patients requiring immediate, constant and continuous attention. This definition includes charges for intensive care, coronary care, and acute care units of a Hospital but does not include charges for a surgical recovery or post-operative room. The unit must meet the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Special Enrollee

The term "Special Enrollee" means an Employee or Dependent who is entitled to and who requests Special Enrollment (1) within 30 days of losing other health coverage; or (2) for a newly acquired Dependent, within 30 days of the marriage, birth, adoption, or placement for adoption. The term "Special Enrollee" also means an employee or Dependent who is entitled to and who requests Special Enrollment within sixty (60) days of losing Medicaid or Children's Health Insurance Coverage (CHIP) due to loss of eligibility, as well as obtaining eligibility for a state premium assistance subsidy under these two programs.

Spinal Manipulation Treatment

Spinal manipulation therapy (defined as the manual manipulation of the spine to restore mobility to the joints and to allow vertebrae to assume their normal position) and other modalities of treatment, including examinations, laboratory services and x-rays provided in connection with such treatment or therapy.

Substance Abuse

Physical dependence on drugs or alcohol. This includes (but is not limited to) dependence on drugs that are medically prescribed.

Temporomandibular Joint (TMJ) Disturbances

Any jaw joint problems including temporomandibular joint syndrome and craniomandibular disorders, or other conditions of the joint that links the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint.

Total Disability

When the Covered Person, if an Employee or regularly employed Dependent spouse, is prevented, solely because of a non-occupational Injury or non-occupational Illness, from engaging in his regular or customary occupation and is performing no work of any kind for compensation or profit; or when any other Dependent, is prevented, solely because of non-occupational Injury or non-occupational Illness, from engaging in all of the normal activities of a person of like age and in good health. Certification of Total Disability must be made by a Physician.

Waiting Period

The specified period of time, if any, an employee must be in an eligible Employee Class before becoming eligible for coverage under the Plan.

XI
STATEMENT OF RIGHTS

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Women's Health and Cancer Rights Act of 1998

This Plan intends to comply with the Women's Health and Cancer Rights Act of 1998, as amended from time to time, as described below. A Covered Person who elects breast reconstruction in connection with a mastectomy also will be covered for:

(1) Reconstruction of the breast on which the mastectomy was performed;
(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
(3) Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Deductible and coinsurance for other benefits under the Plan may also apply to these reconstructive surgery benefits.

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

This Plan intends to comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended from time to time, that requires equity in the provision of mental health and substance-related disorder benefits under group health plans.

Mental health and substance use disorder benefits are defined broadly to mean benefits with respect to services for mental health conditions and substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law. The MHPAEA does not mandate mental health or substance use benefit coverage. However, if a plan offers such coverage, it must be provided at parity in accordance with this Act

The MHPAEA mandates that financial requirements and treatment limitations applicable to mental health / substance use disorder benefits may not be more restrictive than those requirements and limitations placed on medical / surgical benefits.

This equity in coverage will apply to all financial requirements, including deductibles, copayments, coinsurance, and out-of-pocket expenses, and to all treatment limitations, including frequency of treatment, number of visits, days of coverage, or other similar limits.

A group health plan (or coverage) that provides out-of-network coverage for medical / surgical benefits must also provide out-of-network coverage, at parity, for mental health / substance use disorder benefits.

The MHPAEA is protective of any applicable State law. Only a State law that "prevents the application" of this Act will be preempted which means that stronger State parity and other consumer protection laws, if applicable, remain in place.

XII
HOW TO USE YOUR BENEFITS

How To File A Claim

(1) For you to receive benefits under the Plan, a claim must be filed. Many medical providers will submit a claim for you. Generally, medical providers obtain your permission to file a claim for you when you make arrangement for payment. If you submit a claim yourself, you should use a claim form. You may obtain a claim form from your Employer or HealthSmart Benefit Solutions, Inc. After the Claims Administrator receives the required information and/or completed claim form and documentation, benefit determination will be made as soon as administratively possible.

(2) The claim filing procedures and time schedules for the Plan to complete its determination of post-service claims, concurrent decision claims, pre-service claims and urgent care claims, differ based on the category of the claim and such differences are described separately, as necessary. The shorter deadlines for the Plan to complete its determination of pre-service claims and urgent care claims apply only to claims with pre-authorization requirements.

(3) For Hospital bills, simply present your Health Benefit Plan identification card at the admittance office. The Hospital will assist in the coordination of claim payment. A claim must be submitted with an itemized bill.

(4) For other medical bills including x-rays, lab work, surgery, Physician's visits (office and in-Hospital), etc., a claim must be submitted with an itemized bill. Medical providers often file claims for you. If you file your own claim, a claim form must be submitted.

(a) Only one claim filing or claim form is necessary to establish a claim, even if there are different Physicians involved or different services rendered. Remember that separate Illnesses or Injuries are separate claims.

(b) If you file your own claim, complete the Employee information section on the claim form in its entirety.

(c) If you wish benefits to be paid directly to the Hospital or Physician, complete the Authorization To Pay Benefits section on the claim form.

(d) The Physician's diagnosis should be included on the medical provider's itemized bill. The Physician's diagnosis is extremely important and without it the claim cannot be paid.

(e) If you file your own claim, make certain that you have signed the claim form.

(f) An itemized bill will be accepted without a claim form if you have previously submitted a claim form for that specific Illness or Injury.

General Claim Filing Information

(1) Claim forms can be obtained from your Employer or HealthSmart Benefit Solutions, Inc.

(2) <u>All claims relating to benefits covered under the Plan must be filed within the twelve-month period following the date the service is received.</u>

(3) Send the claim and itemized billing to the address listed on your health plan identification card.

(4) An itemized bill must include the following information:

(a) patient's name;
(b) description of each service rendered;
(c) date(s) of each service rendered;
(d) charge for each service rendered;
(e) diagnosis (if more than one diagnosis, indicate which diagnosis relates to specific services rendered); and
(f) name, address and tax identification number of the provider of service.

If you have made payment to the provider of service, make sure the bill is marked paid or is accompanied by a paid receipt.

(5) A separate claim must be submitted for each family member for whom a claim is being made. The Plan maintains separate payment and deductible records on you and each of your Dependents. If you file your own claim, only one claim form is necessary for each Illness or Injury.

Assignment of Benefits

Benefits may be paid to you or directly to your health care provider. Typically, you authorize the Plan to make payment directly to a medical provider at the time you make arrangement for payment following treatment. If you file your own claim, and payment is to be made directly to the provider, be sure to sign the Authorization to Pay Benefits statement directly below your first signature on the claim form. Regardless of who receives payment, you will receive an explanation of benefits showing the amount paid and how it was calculated under the Plan.

Claim Decisions on Claims and Eligibility

Information regarding urgent care claims is provided to a Covered Person under the disclosure requirements of applicable law; the Plan does not make treatment decisions. Any decision to receive treatment must be made between the patient and his or her healthcare provider; however, the Plan will only pay benefits according to the terms, conditions, limitations and exclusions of this Plan.

Urgent Care Claims—An Urgent Care Claim is any claim for medical care or treatment with respect to which:

(1) In the judgment of a prudent layperson possessing an average knowledge of health and medicine could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(2) In the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

There are no Urgent Care requirements under this Plan and therefore, there are no rights to appeal a pre-service Urgent Care claim denial.

Pre-Service Claims—Pre-Service Claims must be submitted to the Plan before the Covered Person receives medical treatment or service. A Pre-Service Claim is any claim for a medical benefit which the Plan terms condition the Covered

Person's receipt of the benefit, in whole or in part, on approval of the benefit before obtaining treatment. Pre-Service Claims are claims decisions that the Plan requires pre-authorization before a Covered Person obtains medical care.

Post-Service Claims—A Post-Service Claim is any claim for a medical benefit under the Plan with respect to which the terms of the Plan do not condition the Covered Person's receipt of the benefit, or any part thereof, on approval of the benefit prior to obtaining medical care, and for which medical treatment has been obtained prior to submission of the claim(s).

In most cases, initial claims decisions on Post-Service Claims will be made within thirty (30) days of the Plan's receipt of the claim. The Plan will provide timely notice of the initial determination once sufficient information is received to make an initial determination, but no later than thirty (30) days after receiving the claim.

Concurrent Care Review—For patients who face early termination or reduction of benefits for a course of treatment previously certified by the Plan, a decision by the Plan to reduce or terminate benefits for ongoing care is considered an Adverse Benefit Determination. (Note: Exhaustion of the Plan's benefit maximums is not an Adverse Benefit Determination.) The Plan will notify the Covered Person sufficiently in advance to allow an appeal for uninterrupted continuing care before the benefit is reduced or terminated. Any request to extend an Urgent Care course of treatment beyond the initially prescribed period of time must be decided within twenty-four (24) hours of the Plan's receipt of the request. The appeal for ongoing care or treatment must be made to the Plan at least twenty-four (24) hours prior to the expiration of the initially prescribed period.

Appealing a Denial of a Pre-Service Claim

If a claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim denial will be provided by the Plan showing:

(1) The reason the claim was denied;
(2) Reference(s) to the specific plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;
(3) Any additional information needed to perfect the claim and why such information is needed; and
(4) An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action following an Adverse Benefit Determination on appeal.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Plan at the address or telephone number shown on the claim denial.
The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

To initiate the first level of benefit review, the Covered Person must submit in writing an appeal or a request for review of the Adverse Benefit Determination to the Plan within one hundred eighty (180) days after the Adverse Benefit Determination. The Covered Person should include any additional information supporting the appeal, or supply the information required by the Plan that was not initially provided, and submit the appeal to the Plan within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period will render the determination final. Any appeal received after the 180-day time period has expired will receive no further consideration.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing, and supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

First Level of Benefit Determination Review

The first level of benefit determination review is done by the Claims Administrator. The Claims Administrator will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within fifteen (15) days following the date the Claims Administrator receives the request for reconsideration.

If, based on the Claims Administrator's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the Claims Administrator, not later than sixty (60) days after receipt of the Claims Administrator's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

Second Level of Benefit Determination Review

The Plan will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by a person(s) who are neither the original decision maker nor the decision maker's subordinate. The Plan cannot give deference to the initial benefit determination. The Plan may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of medical necessity or experimental treatment, the Plan will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination, which contains the same information as notices for the initial determination, within fifteen (15) days.

Appealing a Denial of a Post-Service Claim

If a claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim Explanation of Benefits (EOB) will be provided by the Plan showing:

(1) The reason the claim was denied;
(2) Reference(s) to the specific plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;
(3) Any additional information needed to perfect the claim and why such information is needed; and
(4) An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action following an Adverse Benefit Determination on appeal.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Claims Administrator at the address or telephone number shown on the EOB form.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

To initiate the first level of benefit review, the Covered Person must submit in writing an appeal or a request for review of the Adverse Benefit Determination to the Plan within one hundred eighty (180) days after the Adverse Benefit Determination. The Covered Person should include any additional information supporting the appeal, or supply the information required by the Plan that was not initially provided, and submit the appeal to the Plan within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period will render the determination final. Any appeal received after the 180-day time period has expired will receive no further consideration.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing, and supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

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After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination within a reasonable time, but no later than thirty (30) days from the date the appeal is received by the Plan.

All claim payments are based upon the terms contained in the Plan Document, on file with the Plan Administrator and the Claims Administrator. The Covered Person may request, free of charge, more detailed information, names of any medical professionals consulted and copies of relevant documents, as defined in and required by law, which were used by the Plan to adjudicate the claim.

Independent External Review

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person must request such review in writing within one hundred twenty (120) days after a decision is made upon the second level benefit determination above.

If an independent external review is requested, the Claims Administrator will forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Covered Person of its procedures to submit further information.

The IRO will issue a final decision within forty-five (45) days after receipt of all necessary information.

The decision of the IRO will be final and binding except that the Covered Person shall have an additional right to appeal the matter to a court with jurisdiction.

Claim Decisions on Claims and Eligibility

Information regarding urgent care claims is provided to a Covered Person under the disclosure requirements of applicable law; the Plan does not make treatment decisions. Any decision to receive treatment must be made between the patient and his or her healthcare provider; however, the Plan will only pay benefits according to the terms, conditions, limitations and exclusions of this Plan.

Urgent Care Claims—An Urgent Care Claim is any claim for medical care or treatment with respect to which:

(1) In the judgment of a prudent layperson possessing an average knowledge of health and medicine could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
(2) In the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

There are no Urgent Care requirements under this Plan and therefore, there are no rights to appeal a pre-service Urgent Care claim denial.

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Post-Service Claims—A Post-Service Claim is any claim for a medical benefit under the Plan with respect to which the terms of the Plan do not condition the Covered Person's receipt of the benefit, or any part thereof, on approval of the benefit prior to obtaining medical care, and for which medical treatment has been obtained prior to submission of the claim(s).

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appeal for ongoing care or treatment must be made to the Plan at least twenty-four (24) hours prior to the expiration of the initially prescribed period.

Appealing a Denial of a Pre-Service Claim

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(1) The reason the claim was denied;
(2) Reference(s) to the specific plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;
(3) Any additional information needed to perfect the claim and why such information is needed; and
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If, based on the Claims Administrator's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the Claims Administrator, not

later than sixty (60) days after receipt of the Claims Administrator's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

Second Level of Benefit Determination Review

The Plan will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by a person(s) who are neither the original decision maker nor the decision maker's subordinate. The Plan cannot give deference to the initial benefit determination. The Plan may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of medical necessity or experimental treatment, the Plan will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination, which contains the same information as notices for the initial determination, within fifteen (15) days.

Appealing a Denial of a Post-Service Claim

If a claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim Explanation of Benefits (EOB) will be provided by the Plan showing:

(1) The reason the claim was denied;
(2) Reference(s) to the specific plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;
(3) Any additional information needed to perfect the claim and why such information is needed; and
(4) An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action following an Adverse Benefit Determination on appeal.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Claims Administrator at the address or telephone number shown on the EOB form.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

To initiate the first level of benefit review, the Covered Person must submit in writing an appeal or a request for review of the Adverse Benefit Determination to the Plan within one hundred eighty (180) days after the Adverse Benefit Determination. The Covered Person should include any additional information supporting the appeal, or supply the information required by the Plan that was not initially provided, and submit the appeal to the Plan within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period will render the determination final. Any appeal received after the 180-day time period has expired will receive no further consideration.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing, and supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

First Level of Benefit Determination Review

The first level of benefit determination review is done by the Claims Administrator. The Claims Administrator will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within thirty (30) days following the date the Claims Administrator receives the request for reconsideration.

If, based on the Claims Administrator's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the Claims Administrator, not later than sixty (60) days after receipt of the Claims Administrator's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

Second Level of Benefit Determination Review

The Plan will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by a person(s) who is neither the original decisionmaker nor the decisionmaker's subordinate. The Plan cannot give deference to the initial benefit determination. The Plan may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of medical necessity or experimental treatment, the Plan will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination within a reasonable time, but no later than thirty (30) days from the date the appeal is received by the Plan.

All claim payments are based upon the terms contained in the Plan Document, on file with the Plan Administrator and the Claims Administrator. The Covered Person may request, free of charge, more detailed information, names of any medical professionals consulted and copies of relevant documents, as defined in and required by law, which were used by the Plan to adjudicate the claim.

Independent External Review

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person must request such review in writing within one hundred twenty (120) days after a decision is made upon the second level benefit determination above.

If an independent external review is requested, the Claims Administrator will forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Covered Person of its procedures to submit further information.

The IRO will issue a final decision within forty-five (45) days after receipt of all necessary information.

The decision of the IRO will be final and binding except that the Covered Person shall have an additional right to appeal the matter to a court with jurisdiction.

EXTERNAL REVIEW PROCESS UNDER THE PATIENT PROTECTION ACT OF 1999

This Plan intends to comply with the Patient Protection Act of 1999 as it applies to public employee benefit plans (Ohio Revised Code §§ 3923.75 to 3923.79), as amended from time to time, which is effective May 1, 2000.

The Patient Protection Act adds a separate and additional process for review of a denied claim following a Covered Person's exhaustion of the Plan's internal claims appeal process. The Covered Person must use all the Plan's established steps for internal appeal of a denied claim before invoking a review under the Patient Protection Act. Due to the comprehensive nature of the Patient Protection Act of 1999, the following is intended only as a summary of the law as it applies to public employee benefit plans.

Review of Claim Denial for Service Not Covered

The Ohio Department of Insurance will review written requests from Covered Persons who have been denied coverage on the grounds that the service is not covered under the contractual terms of the Plan.

If the Plan denies the service because it is not a covered service, a Covered Person may request a review from the Ohio Department of Insurance at:

The Ohio Department of Insurance
Consumer Services Division
2100 Stella Court
Columbus, Ohio 43215-1067
1-800-686-1526

The Ohio Department of Insurance shall notify the Covered Person and the Plan of its determination, or that it is not able to make a determination because the determination requires the resolution of a medical issue.

If the determination requires the resolution of a medical issue, the Plan shall afford the Covered Person an opportunity for external review by

an independent review organization. If the Ohio Department of Insurance notifies the Plan that the health care service is not a covered service, then the Plan is not required to cover the service or afford the Covered Person an external review.

External Review of Coverage Denial

The Plan will afford the Covered Person an external review of a coverage denial when requested if the Plan has determined that the health care service is not medically necessary and the proposed service, plus any ancillary services and follow-up care, will cost the Covered Person more than five hundred dollars ($500).

An external review must be requested in writing. If the Covered Person has a condition that requires expedited review, the review may be requested orally or by electronic means. Written confirmation of the request must be submitted to the Plan not later than five (5) days after the oral or electronic request is made.

Except in the case of an expedited review, a request for an external review must be accompanied by written certifications that the proposed service, plus any ancillary services and follow-up care, will cost more than five hundred dollars ($500). A Covered Person shall not be required to pay for any part of the cost of any external review.

A request for an external review shall be denied if the request is received by the Plan later than sixty (60) days after the Covered Person received notice from the Ohio Department of Insurance that making the determination requires the resolution of a medical issue. The provider or health care facility may not request a review without the prior consent of the Covered Person.

Expedited Review of Coverage Denial

For an expedited review, the Covered Person's provider must certify that the Covered Person's condition could, in the absence of immediate medical attention, result in any of the following:

(a) Placing the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or the unborn child, in serious jeopardy;
(b) Serious impairment to bodily functions; or
(c) Serious dysfunction of any bodily organ or part.

In the case of an expedited review, the independent review organization shall issue a written decision not later than seven (7) days after the filing of the request for review. In all other cases, the independent review organization shall issue a written decision not later than thirty (30) days after the filing of the request. The independent review organization shall send a copy of its decision to the Plan and the Covered Person. If the provider rendering health care services requested the review, the independent review organization shall also send a copy of its decision to the provider.

The independent review organization shall base its decision on the information submitted. In making its decision, the independent review organization shall consider safety, efficacy, appropriateness, and cost-effectiveness.

The Plan shall provide any coverage determined by the independent review organization's decision to be medically necessary, subject to the other terms, limitations, and conditions of the Plan.

External Review of Coverage Denial for Experimental Treatment of Terminal Conditions

The Plan will afford an external review regarding experimental treatment to examine the Plan's coverage decision for a Covered Person who meets all of the following criteria:

(a) The Covered Person has a diagnosed terminal condition that has a high probability of causing death within two years;
(b) The Covered Person requests a review not later than sixty (60) days after receipt by the Covered Person of notice from the Ohio Department of Insurance that making a determination requires resolution of a medical issue;
(c) The Covered Person's physician certifies the terminal condition, and that standard therapies have not been effective in improving the condition, and that standard therapies are not medically appropriate;
(d) The Covered Person's physician has recommended treatment that the physician certifies, in writing, is likely to be more beneficial to the Covered Person, in the physician's opinion, than standard therapies, or the Covered Person has requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition;
(e) The Covered Person has been denied coverage by the Plan for treatment recommended or requested, and has exhausted all internal appeals; and
(f) The treatment, for which coverage has been denied, would be a covered health care service except for the Plans' determination that the treatment is experimental or investigational.

A review shall be requested in writing, except that if the Covered Person's physician determines that a therapy would be significantly less effective if not promptly initiated, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request shall be submitted to the Plan not later than five (5) days after the oral or written request is submitted. For an expedited review, the Covered Person's provider must certify that the requested or recommended therapy would be significantly less effective if not promptly initiated.

A Covered Person shall be notified by the Plan of the opportunity for external review of a denied claim for experimental treatment of a terminal illness within thirty (30) business days after the Plan denies coverage.

The opinion of the majority of the experts on the external review panel is binding on the Plan with respect to that Covered Person. If the opinions of the experts on the panel are evenly divided as to whether the therapy should be covered, the Plan's final decision shall be in favor of coverage. If less than a majority of the experts on the panel recommend coverage of the therapy, the Plan may, in its discretion, cover the therapy. However, any coverage is subject to the terms, limitations, and conditions of the Plan. The Plan will annually file a certificate with the Ohio Department of Insurance certifying the Plan's compliance with this section.