EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST

EMPLOYEE MEDICAL BENEFIT PLAN

Plan Document and Summary Plan Description
Effective: September 1, 2017

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ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Egyptian Area Schools Employee Benefit Trust (the "Trust" or the "Plan Sponsor") as of September 1, 2017, hereby sets forth the provisions of the Egyptian Area Schools Employee Medical Benefit Plan (the "Plan"). By signing the Adoption Agreement, each Participating Employer (the "Participating Employer"), has authorized the Plan Sponsor to adopt and amend the Plan from to time. The Plan Sponsor has adopted this Plan for the exclusive benefit of eligible Employees and Retirees and their eligible Dependents.

1.01 Effective Date

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

1.02 Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

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

Board of Managers of the Egyptian Area Schools Employee Benefit Trust

By: _____

Name: _____

Date: _____

Title: _____

ARTICLE II
INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

2.01 Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund or trust established by the Plan Sponsor and self-funded with contributions from Participants and Participating Employers. Participants in the Plan may be required to contribute toward their benefits in amounts determined by their Employers.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Sickness. The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by the Trust and may be inspected at any time during normal working hours by any Participant. A copy of the Plan is also available on the Trust website at www.egtrust.org.

2.02 If You Have Questions

If you have any questions about information in this document or about your benefits or a bill you receive from a provider, please contact your HealthSCOPE Benefits Customer Care at 1-800-397-9598.

2.03 General Plan Information

Name of Plan:	**Egyptian Area Schools Employee Medical Benefit Plan**
Plan Sponsor: **(Named Fiduciary)**	**Board of Managers of the Egyptian Area Schools Employee Benefit Trust** **c/o HealthSCOPE Benefits, Inc.** **27 Corporate Hill Drive** **Little Rock, AR 72205** **501-225-1551** Each Participating Employer selects a representative to serve on the Board of Managers. You may obtain the name and address of the representative of your Employer from your Employer.
Plan Administrator:	**Board of Managers of the Egyptian Area Schools Employee Benefit Trust** **c/o HealthSCOPE Benefits, Inc.** **27 Corporate Hill Drive** **Little Rock, AR 72205** **501-225-1551**
Plan Sponsor ID No. (EIN):	**37-1156166**
Plan Status:	**Non-Grandfathered**
Source of Funding:	**Self-Funded** Contributions are made to the Plan by the Employers and Employees and are accumulated in a Trust Fund. Benefits are paid directly from the Trust by the Third Party Administrator. Each Participating Employer determines the contribution, if any, that must be paid by its Employees.

Plan Year:	**September 1 through August 31**
Third Party Administrator:	**HealthSCOPE Benefits, Inc.** **27 Corporate Hill Drive** **Little Rock, AR 72205** **501-225-1551**
Participating Employer(s):	**Contact your Employer or the Third Party Administrator to determine whether your Employer is a Participating Employer in the Trust.**
Agent for Service of Process:	**Chairman, Board of Managers** **Egyptian Area Schools Employee Benefit Trust** **c/o HealthSCOPE Benefits, Inc.** **27 Corporate Hill Drive** **Little Rock, AR 72205** **501-225-1551**

2.04 Legal Entity; Service of Process

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

2.05 Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Trust and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of any Participating Employer or to interfere with the right of the Participating Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Participating Employer with the bargaining representatives of any Employees.

2.06 Applicable Law

The Plan is a self-funded nonfederal governmental plan which is not subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and Employer contributions, and is subject to applicable Federal and Illinois state laws.

2.07 Discretionary Authority

The Plan Sponsor shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participant's rights; and to determine all questions of fact and law arising under the Plan.

ARTICLE III
GENERAL OVERVIEW OF THE PLAN

3.01 Schedule of Benefits

The Plan is designed to provide Participants with access to high quality care at an affordable cost. The Plan offers multiple plan design options with different levels of Deductibles, Coinsurance, Out-of-Pocket Maximums and premiums. Each Participating Employer selects the plans offered to its Employees, up to a maximum of 5 plans. Some plans are HSA qualified plans, which are high deductible health plans designed to allow Participants to make contributions to Health Savings Accounts, as explained below. The Schedule of Benefits for each plan is available from your Employer and is posted on the Trust website at www.egtrust.org.

3.02 Free Choice of Providers

You have a free choice of using any provider and there is only one level of benefits within each plan option. You, together with your provider, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

While you are free to choose your provider, the Plan requires you to pre-certify Hospital admissions and many outpatient services. This process is explained in Article IV.

Physician and Ancillary Services

The PHCS Physician and Ancillary Provider Network is offered for physician and ancillary services (such as DME, radiology, physical therapy, etc.). This gives you access to a wide network of physicians at discounted fees. The Plan uses the PHCS network for physicians and ancillary providers only. The Plan does not use the PHCS network for services and supplies provided by Hospitals, Ambulatory Surgery Centers, infusion therapy centers, dialysis clinics or other Facilities. You may search online at www.multiplan.com/healthscope for a PHCS preferred provider. In some areas the Plan has entered into contracts with certain providers for the benefit of Participants. This is referred to as the "Egyptian Trust Network." Information about the Egyptian Trust Network is on the Trust website at www.egtrust.org. You may also contact HealthSCOPE Benefits Customer Care at 1-800-397-9598 to locate a preferred provider.

Hospital and Facility Services

The Plan provides Participants with open access to any Facility or Hospital of your choosing. Examples of Facilities include:

- Hospitals (Inpatient and Outpatient treatment);
- Inpatient Facilities (such as Skilled Nursing Facilities or Hospice Facilities);
- Outpatient Facilities (such as Rehabilitation Hospitals, Infusion Therapy Centers, or Hospice Facilities)
- Inpatient and Outpatient Facilities for treatment of Mental or Nervous Disorders, or Substance Abuse Disorders;
- Air/ground ambulance;
- Ambulatory Surgery Centers;
- Dialysis clinics.

When you need care from a Hospital or other Facility, Value-Based Fair Price comes into play to keep your costs down. Your physician will recommend a Hospital or outpatient Facility and pre-certify your treatment, as usual. Based on rates established by Medicare and other resources, a fair price will be identified for your treatment. The facility will be notified when the service is pre-certified of the Plan's allowable charge, which is almost always lower than what the facility would normally charge. Some Hospitals and other Facilities have agreed to contracts with the Plan for the benefit of Plan Participants. Information about facilities in the Egyptian Trust Network is on the Trust website at www.egtrust.org. In all cases, you will be responsible for any Copays, Deductible, and Coinsurance up to the maximum amounts shown in your Schedule of Benefits.

3.03 Balance Billing

In some cases a Hospital or other provider may bill you for an amount that exceeds the amount shown as the Patient Responsibility on your Explanation of Benefits (EOB). **Do not pay more than the Patient Responsibility shown on your EOB.** If you receive a bill for a greater amount, immediately contact HealthSCOPE Benefits Customer Care at 1-800-397-9598 so a representative can be assigned to resolve your claim with the provider. This process is described further in the section in Article X captioned Patient Advocacy Center and Balance Billing.

3.04 Your Costs

You must pay for a certain portion of the cost of Covered Expenses under the Plan, including (as applicable) any Deductible, Copay and Coinsurance percentage that is not paid by the Plan, up to the Out-of-Pocket Maximum amounts shown in your Schedule of Benefits.

Coinsurance

Coinsurance is the percentage of Covered Expenses the Plan and the Participant are required to pay. The Plan's coinsurance is shown in the Schedule of Benefits. The Participant's coinsurance is the difference between the Plan's coinsurance and 100%.

Copay

A Copay is a specific dollar amount of a Covered Expense that is your responsibility, as shown in the Schedule of Benefits. A Copay may be applied for each occurrence of certain types of services and for prescription drugs in most plans. Depending on the particular plan, Copays may or may not apply toward satisfaction of the Deductible and/or the Out-of-Pocket Maximum, as indicated on your Schedule of Benefits. Copays apply toward satisfaction of the ACA Maximum in plans which have both an Out-of-Pocket Maximum and an ACA Maximum.

Deductible

A Deductible is the amount shown in the Schedule of Benefits which you must pay during any Calendar Year before most Covered Expenses are payable under the Plan. The family Deductible, as shown in the Schedule of Benefits, is the maximum amount you must pay for all covered family members during a Calendar Year before the Plan will start paying for Covered Expenses. Some services are not subject to the Deductible, as explained in the Schedule of Benefits.

Some of the HSA qualified plans (Plans HDHP and H1) contain a **"non-embedded deductible".** This means if you choose to cover Dependents, the family Deductible will apply to all claims until the family amount is met before benefits will be paid for Covered Expenses (other than Preventive Care) for any covered family member. Refer to your Schedule of Benefits for more information.

Out-of-Pocket Maximum

An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

Some plans have two out-of-pocket limits, the Calendar Year Out-of-Pocket Maximum and the ACA Cost Share Out-of-Pocket Maximum (or High Deductible Plan Maximum) described below.

The individual Out-of-Pocket Maximum applies for each individual Participant. The family Out-of-Pocket Maximum applies collectively to all covered family members. The family Out-of-Pocket Maximum is the maximum amount that must be satisfied by covered family members during a Calendar Year. The entire family Out-of-Pocket Maximum must be satisfied; but no individual in a family is required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum. When the family reaches the family Out-of-Pocket Maximum, the Plan will pay 100% of Covered Expenses for all covered family members during the remainder of that Calendar Year.

Please note, not all Covered Expenses in all plans are eligible to accumulate toward your Out-of-Pocket Maximum. Refer to your Schedule of Benefits for the list of services and how they accumulate.

ACA Cost Share Out-of-Pocket Maximum
Some plans have a second, higher out-of-pocket limit referred to as the ACA Cost Share Out-of-Pocket Maximum (or the High Deductible Plan Maximum for Plan HDHP). The Schedule of Benefits lists the services that accumulate toward these separate out-of-pocket limits.

Once you have paid the applicable Out-of-Pocket Maximum for Covered Expenses Incurred during a Calendar Year, the Plan will reimburse additional Covered Expenses Incurred during that year at 100%.

The Plan will not reimburse any expense that is not a Covered Expense. In addition, you must pay any penalties for failure to comply with requirements of the Medical Management provisions of the Plan (if applicable) or any other penalty that is otherwise stated in this Plan. This could result in you having to pay a significant portion of your claim. None of these amounts will accumulate toward any Out-of-Pocket Maximum.

If you have any questions about whether an expense is a Covered Expense or whether it is eligible for accumulation toward your Out-of-Pocket Maximum or the ACA Out-of-Pocket Maximum, please contact HealthSCOPE Benefits Customer Care at 1-800-397-9598.

Copay for Hospital Admissions and Outpatient Surgery
In many plans you must pay a Copay for each new Hospital admission and each outpatient surgical procedure performed at a Hospital or Ambulatory Surgical Facility, but not more than 3 Copays for any individual Participant in a Calendar Year. However, the Inpatient Hospital Copay will be waived if the person is admitted directly from the Emergency Room as an Inpatient to the Hospital. The amount of the Copay is shown on the Schedule of Benefits. If you are discharged from the Hospital and readmitted for any reason within 7 days, you will not be charged another Copay for readmission. If an individual Participant has 3 or more Hospital admissions and/or surgical procedures in the same Calendar Year, the Copay will be waived for any additional Hospital admissions or surgical procedures in the same Calendar Year. You must contact HealthSCOPE Benefits Customer Care at 1-800-397-9598 to request this waiver. In most plans these Copays cannot be used to satisfy the Calendar Year Deductible amount or the annual Out-of-Pocket Maximum.

3.05 About High Deductible Plans and Health Savings Accounts

Certain plans, including Plan HDHP and the H Plans, are high deductible health plans that are designed to allow you to contribute to a Health Savings Account (HSA) provided that you meet all requirements set forth in the Internal Revenue Code. You are not required to have an HSA. You may enroll in these Plans without establishing an HSA, but you may not contribute to an HSA unless you are enrolled in a qualified high deductible plan and meet other IRS requirements. One of the key requirements is that you may not be enrolled for coverage under any other health plan that pays expenses before your meet the high deductible (including but not limited to Medicare or an employer HRA that reimburses expenses before you meet the deductible) that is not a qualified high deductible plan.

An HSA is a trust account established by an eligible individual at a bank, insurance company or other qualified financial institution. Funds can be contributed to, invested and accumulated in the HSA on a tax-free basis and used to pay for uninsured health care costs. HSA contributions may be made by an eligible individual's employer, by the individual or both. Under federal law, employer contributions are not taxable to the employee. An individual may make contributions to an HSA pre-tax through a Section 125 cafeteria plan or after-tax and then claim a deduction on the individual's federal tax return.

For 2018, up to $3,450 may be contributed to an HSA on behalf of an eligible individual for individual coverage and up to $6,900 for family coverage. An account owner may contribute an additional $1,000 for 2018 if the account owner will reach at least age 55 in 2018.

Contributions and investment earnings belong to the HSA account owner and can never be forfeited. The account owner may move the funds at any time to a different qualified HSA trustee. Funds may be withdrawn from the HSA tax free to pay qualified medical expenses for the individual and his or her tax dependents. For example, if you establish an HSA you may withdraw funds from your HSA to pay medical expenses you are required to pay before you meet the Calendar Year Deductible under your high deductible plan. You may instead pay those expenses from

other funds and continue to accumulate funds tax-free in the HSA to be used for qualified medical expenses in a later year.

Funds withdrawn from an HSA for any purpose other than payment for qualified medical expenses will be subject to income and excise taxes. The account owner is responsible for maintaining documentation to verify that withdrawals are made for qualified medical expenses. The account owner is also responsible for reporting all HSA contributions and distributions to IRS by filing IRS Form 8889 with his or her individual tax return (IRS Form 1040) each year.

The laws governing HSAs are complex and may change from time to time. You should talk with your own tax advisor or an HSA provider before deciding to establish an HSA to make sure you meet the legal requirements and understand your obligations as the account owner. For more information about HSAs, including who is eligible, other health coverage that might disqualify you from being eligible, contribution limits and other rules, see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans) at www.irs.gov.

3.06 Teladoc

The Plan provides coverage for telephone consults or e-mail consults provided by a Teladoc Physician for nonemergent care. Common examples of when to use Teladoc for non-emergent medical care include but are not limited to the following: care after office hours; care while on vacation; to refill a short term (non-DEA controlled) prescription; second opinions; and research and advice on a particular health condition. To utilize this service, please visit www.MyDrConsult.com directly or you may visit www.egtrust.org to hyperlink to Teladoc. If you do not have internet service available, please call 1-800-362-2667 to use this service. If a prescription is requested, you will be required to complete an electronic medical record prior to receiving a consult. This electronic medical record is confidential and will be maintained by the Teladoc program. For any questions about the Teladoc benefit, please contact HealthSCOPE Benefits Customer Care at 1-800-397-9598.

This benefit does not include telephone or e-mail consults from your regular Physician; it only includes coverage for telephone or e-mail consults to the extent the Physician who is consulted participates in the Teladoc program. The Teladoc benefit is not available in the State of Oklahoma.

3.07 Medical Expense Audit Bonus

The Plan offers an incentive to encourage you to exam and self-audit your medical bills to ensure the amounts billed by any provider accurately reflect the services and supplies you received. You are asked to review all medical charges and verify that each itemized service has been received and the bill does not represent either an overcharge or a charge for services never received. This self-auditing procedure is strictly voluntary; however, it is to the advantage of the Plan as well as to you to avoid unnecessary payment of healthcare costs. In the event a self-audit results in elimination or reduction of benefits paid, 50% of the amount saved in Hospital or outpatient facility charges will be reimbursed directly to the Employee (subject to a $10 minimum payment and a $250 maximum payment per Hospital stay or Outpatient facility charge), provided the savings are accurately documented, and satisfactory evidence is submitted to the Third Party Administrator (e.g., a copy of the incorrect bill and a copy of the corrected billing). This self-audit credit is in addition to the payment of all other applicable Plan benefits for legitimate medical expenses. This credit will not be payable for expenses in excess of the Reasonable and Allowable Amount or expenses that are not covered under the Plan, regardless of whether benefits paid are reduced.

3.08 Claims Audit

The Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are in excess of the Reasonable and Allowable Amount and/or not Medically Necessary, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records. Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Reasonable and Allowable Amount or other applicable provisions, as outlined in this Plan document.

ARTICLE IV
MEDICAL MANAGEMENT AND PRE-CERTIFICATION REQUIREMENTS

4.01 General Limits

Payment for eligible expenses is subject to all exclusions, limitations and provisions in this Plan. Benefits for Pregnancy expenses are covered only for Employees and their Spouses or Civil Union Partners and are paid the same as any other Sickness. Certain preventive services related to a Dependent Child's Pregnancy may be covered. See the Preventive Care section under Eligible Medical Expenses for more information.

Medical Management includes hospital pre-admission certification, continued stay review, length-of-stay determination and discharge planning. These programs are designed to ensure that Medically Necessary, high-quality patient care is provided and enables maximum benefits under the Plan.

4.02 Services That Must Be Pre-certified

Inpatient Services. The following inpatient services require pre-certification or reimbursement from the Plan may be reduced:

- Inpatient Hospitalization;
- Transplant Candidacy Evaluation and Transplant (organ and/or tissue);
- Inpatient Mental/Nervous facility based programs;
- Inpatient Substance Abuse facility based programs;
- Maternity confinements exceeding the standard 48 hour vaginal delivery and 96 hour c-section; and
- Skilled Nursing Facility stays.

The Plan will automatically pre-authorize a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, but it is important to have your Physician call to obtain pre-certification in case a longer stay is needed.

Outpatient Services. The following outpatient services require pre-certification:

- 23-hour observation stays;
- Hospice services;
- Dialysis;
- High-Tech Radiology Services (CT, MRA, MRI, PET);
- Home Health Services;
- Infusion Services in excess of $1,500;
- Chemotherapy;
- Radiation; and
- Durable Medical Equipment in excess of $1,500 (including prosthetics).

In addition, pre-certification is required for all Outpatient Surgeries not performed in a Physician's office and all the procedures/services listed below, regardless of place of service:

- Autism Spectrum Disorder treatment;
- Any drug over $1,500 per dose;
- Biologic drugs;
- Chemotherapeutic drugs;
- Deviated septum/nasal surgery;
- Electron Beam Tomography (EBCT);
- Endoscopic procedures;
- Epidural/facet and trigger point injections;

- Extended Nursing Facility;
- Infusions (Infusion Therapy) of any type over $1,500;
- Long Term Acute Care (LTAC);
- MRI/CT/PET Scan (excluding bone density studies);
- Physical, Occupational, and Speech Therapy;
- Psychiatric Treatment: Intensive Outpatient, Residential, Partial;
- Rehabilitation Facility;
- Rehabilitation for Substance Abuse: Outpatient, Residential, Partial;
- Skilled Nursing Facility (SNF); and
- Varicose Vein Ligation.

4.03 Pre-Certification Procedures

Inpatient Pre-certification and Utilization Management. Whenever a Participant is advised that Inpatient Hospital care is needed, it is the Participant's responsibility to make sure the Physician calls the pre-certification department at its toll-free number, **1-800-397-9598**, at least 7 days in advance of a scheduled procedure. The review process will continue, as outlined below, until the Participant is discharged from the Hospital.

Pre-certification is also required for Inpatient admission to skilled nursing facilities, convalescent or rehabilitation facilities.

Pre-certification of Outpatient Services
Many outpatient services also require pre-certification, as listed above. Again, your Provider should contact the pre-certification department, at **1-800-397-9598**, at least 7 days in advance of any scheduled procedure which requires pre-certification.

Urgent Care or Emergency Admissions
If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant should follow the Physician's instructions carefully and contact the pre-certification department as follows:

1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within 48 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient; and
2. For Emergency admissions on a weekday, a call to the pre-certification department must be made within 24 hours after the admission date.

The Plan does not require the Participant to obtain approval of a medical service prior to getting treatment for an urgent care or emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Non-emergency Admissions and Procedures
For Inpatient Hospital stays and or other procedures which require pre-certification and are scheduled in advance, a call to the pre-certification department should be completed at least 7 days before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the request. An on-line expert system that features state-of-the-art, widely accepted clinical review criteria is used to effectively guide the review process. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement and/or the requested procedure is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during any confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board-certified Physician advisor to ask if the proposed treatment plan is appropriate. If not, the treating Physician will have an opportunity to appeal any decision not to pre-certify the requested care or to recommend an alternate treatment plan.

At the end of a Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

4.04 Penalty for Failure to Pre-Certify When Required

There is a penalty if you do not follow the pre-certification requirements for a scheduled Hospital admission or procedure. If you fail to notify the pre-certification department of any Inpatient Hospital stay or other procedure which requires pre-certification as provided above, your benefit will be reduced by 50% to a maximum of $250 per inpatient confinement or per course of treatment or therapy for the services listed. You will be responsible for payment of the part of the charge that is not paid by the Plan.

4.05 Alternate Course of Treatment

Certain types of conditions, such as spinal cord Injuries, cancer, AIDS or premature births, may require long-term, or perhaps lifetime, care. The claims selected will be evaluated as to present course of treatment and alternate care possibilities.

If the Plan Administrator should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, even if these expenses normally would not be eligible for payment under the Plan. In the event the Participant and the attending Physician select a more expensive course of treatment, coverage under the Plan will be based upon the charge allowed for the alternate, less expensive, course of treatment.

4.06 Second Surgical Opinion

If a Physician recommends Surgery for a Participant, the Participant may request a second opinion as to whether or not the Surgery is appropriate for the patient. The Plan **recommends** that a second opinion be obtained **prior to** the following Surgeries:

1. Adenoidectomy;
2. Bunionectomy;
3. Cataract removal;
4. Coronary Bypass;
5. Cholecystectomy (removal of gallbladder);
6. Dilation and curettage;
7. Hammer Toe repair;
8. Hemorrhoidectomy;
9. Herniography;
10. Hysterectomy;
11. Laminectomy (removal of spinal disc);
12. Mastectomy;
13. Meniscectomy (removal of knee cartilage, including arthroscopic approach);
14. Nasal Surgery (repair of deviated nasal septum, bone or cartilage);
15. Prostatectomy (removal of all or part of prostate);
16. Release for entrapment of medial nerve (Carpal Tunnel Syndrome);
17. Tonsillectomy; and
18. Varicose veins (tying off and stripping).

When a second opinion is requested, the Plan will pay 100% of Reasonable and Allowable fees incurred for that opinion along with laboratory, x-ray and other Medically Necessary services ordered by the second Physician without application of the Deductible. Second opinions for cosmetic Surgery, normal obstetrical delivery and Surgeries that require only local anesthesia are not covered. If the second opinion does not concur with the first, the Plan will pay for a third opinion as outlined above. The second or third opinion must be given within 90 days of the first.

In all cases where a second opinion is requested, the original recommendation for Surgery must have been obtained from a Physician licensed in the medical specialty under which the recommended Surgery falls. The Physician consulted for the second opinion must be licensed in the same medical specialty and may not be a partner of or in association with the original Physician.

ARTICLE V
DEFINITIONS

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

"Accident"
"Accident" shall mean a sudden and unforeseen event, definite as to time and place, or a deliberate act resulting in unforeseen consequences.

"Accidental Bodily Injury"
"Accidental Bodily Injury" shall mean an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

"Adverse Benefit Determination"
"Adverse Benefit Determination" shall mean any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

"Affordable Care Act" or "ACA"
The "Affordable Care Act" or "ACA" means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act or ACA to refer to the health care reform law.

"AHA"
"AHA" shall mean the American Hospital Association.

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

"AMA"
"AMA" shall mean the American Medical Association.

"**Allowable Expenses"**
"Allowable Expenses" shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some Other Plan provides benefits in the form of services rather than cash payments, the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of each service rendered, by

determining the amount that would be payable in accordance with the terms of the Plan, and that value shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore, whether or not it is actually made.

"Ambulatory Surgical Center"
"Ambulatory Surgical Center" shall mean any public or private State licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures, with continuous Physician services and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

"Approved Clinical Trial"
"Approved Clinical Trial" shall mean a phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the FDA (if such application is required). The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs"). A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis.

"Assignment of Benefits"
The term "Assignment of Benefits" shall mean an arrangement whereby the Participant assigns his or her right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive Plan payments are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

"Autism Spectrum Disorders"
"Autism Spectrum Disorders" shall mean pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

"Birthing Center"
"Birthing Center" shall mean a facility that meets professionally recognized standards and all of the following requirements:

1. It mainly provides an outpatient setting for childbirth following a normal, uncomplicated Pregnancy, in a home-like atmosphere.
2. It has the following: at least 2 delivery rooms; all the medical equipment needed to support the services furnished by the facility; laboratory diagnostic facilities; and emergency equipment, trays, and supplies for use in life threatening situations.
3. It has medical staff that: is supervised by a Physician on a full-time basis; and includes a Registered Nurse at all times when Participants are at the facility.
4. If it is not part of a Hospital, it has a written agreement with a local Hospital and a local ambulance company for the immediate transfer of Participants who develop complications or who require either pre or post-natal care.

5. It admits only Participants who: have undergone an educational program to prepare them for the birth; and have medical records of adequate prenatal care.
6. It schedules confinements of not more than 24 hours for a birth.
7. It maintains medical records for each Participant.
8. It complies with all licensing and other legal requirements that apply.
9. It is not the office or clinic of one or more Physicians or a specialized facility other than a Birthing Center.

"Calendar Year"
"Calendar Year" means January 1 – December 31.

"Cardiac Care Unit"
"Cardiac Care Unit" shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the treatment of patients who require special medical attention because of their critical condition;
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
4. It contains at least two beds for the accommodation of critically ill patients; and
5. It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

"Cardiac Rehabilitation"
"Cardiac Rehabilitation" Services or "Cardiac Rehab" Services shall mean a comprehensive exercise, education, and behavioral modification program designed to improve the physical and emotional condition of patients after heart surgery, frequently beginning in a hospital setting and continuing on an outpatient basis after the patient is discharged over a period of 6 to 12 months, divided into the following three phases:

Phase 1: Begins during a patient's hospital stay and consists of education and highly controlled exercises.
Phase 2: Twelve-week outpatient program consisting of 40 minutes of aerobic exercise, 3 times a week.
Phase 3: A non-monitored but supervised exercise program.

"Centers of Excellence"
"Centers of Excellence" shall mean medical care facilities that have met stringent criteria for quality care for highly specialized services such as organ transplantation and other procedures. These centers have the greatest experience in performing transplant and other eligible procedures and the best survival rates. The Plan Administrator shall determine the Centers of Excellence available for various procedures.

Any Participant may contact the Third Party Administrator to initiate the pre-certification process resulting in a referral to a Center of Excellence for an eligible procedure. The Third Party Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all admissions taking place at a Center of Excellence.

If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

"Certificate of Coverage"

"Certificate of Coverage" shall mean a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

"CHIP"
"CHIP" refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

"CHIPRA"
"CHIPRA" refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

"Chiropractic Care"
"Chiropractic Care" shall mean skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Provider to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

"Claim Determination Period"
"Claim Determination Period" shall mean each plan year.

"Civil Union Partner"
"Civil Union Partner" shall mean an individual of the same or opposite sex registered under or recognized by Illinois law as the Employee's civil union partner. A domestic partnership or civil union that was legally entered into under the laws of another state is recognized by Illinois as a civil union. The Employee will be required to submit an affidavit of civil union or other documentation issued under the applicable state law to the Participating Employer. After the civil union with the Employee has legally terminated, the former Civil Union Partner will not be considered an Eligible Dependent.

"Clean Claim"
A "Clean Claim" is a claim for a Covered Expense that (a) is timely received by the Third Party Administrator; (b) (i) when submitted via paper has all the elements of the UB 04 or CMS 1500 (or successor standard) forms; or (ii) when submitted via an electronic transaction, uses only permitted transaction code sets (e.g. CPT4, ICD9, ICD10, HCPCS) and has all the elements of the standard electronic formats required by applicable Federal authority; (c) is a claim for which the Plan is the primary payor or the Plan's responsibility as a secondary payor has been established; (d) contains no defect, error or other shortcoming resulting in the need for additional information to adjudicate the claim; and (e) does not lack necessary substantiating documentation to completely adjudicate the claim.

A Clean Claim does not include a claim that is being reviewed for the Reasonable and Allowable Amount payable under the terms of the Plan. Any claim over $100,000 must be accompanied by a valid itemization, and submitted to the Third Party Administrator before it will be deemed a Clean Claim. The Third Party Administrator may require an itemized bill for any claim, regardless of dollar amount.

"COBRA"
"COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Cosmetic Surgery"
"Cosmetic Surgery" shall mean any Surgery, service, Drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

"Covered Expense"
Those Medically Necessary services, supplies and/or treatment that are covered under this Plan. Covered Expenses does not necessarily mean the actual charge made nor the specific service or supply furnished to a Participant by a

Provider or Facility. Charges for services, supplies, and/or treatments meant to treat or correct a preventable condition or cost which arises solely due to a Provider or Facility's medical error are not considered Covered Expenses. A finding of Provider or Facility negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered an Excess Charge or not a Covered Expense.

All treatment is subject to benefit payment maximums shown in the Schedule of Benefits and as determined elsewhere in this document.

"Covered Mental Health Service Providers"
"Covered Mental Health Service Providers" include physicians (M.D. or D.O.), Ph.D. clinical psychologists and masters' level counselors (M.A. or M.S.W.), provided they are licensed in the political jurisdiction where practicing, acting within the scope of their licenses and performing services ordered by an M.D., D.O. or a Ph.D. clinical psychologist.

"Custodial Care"
"Custodial Care" shall mean care or confinement provided primarily for the maintenance of the Participant, essentially designed to assist the Participant, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

"Deductible"
"Deductible" shall mean an amount of money that is paid once a calendar year per Participant and Family Unit. Unless otherwise stated, the Deductible must be paid before any money is paid by the Plan for most Covered Expenses. Each calendar year, a new Deductible amount is required. Please refer to your Schedule of Benefits for information explaining how your Deductible accumulates.

"Dentist"
"Dentist" shall mean an individual holding a D.D.S. or D.M.D. degree, licensed to practice dentistry in the jurisdiction where such services are provided.

"Dependent"
"Dependent" shall mean one or more of the following person(s):

1. An Employee's lawfully married spouse of the same or opposite sex.
2. An Employee's Civil Union Partner of the same or opposite sex if the union is registered under or recognized by Illinois law, including a domestic partner.
3. An Employee's Child who is less than 26 years of age. Coverage shall continue through the end of the month in which the Child reaches age 26.
    a. "Child" may include an Employee's natural born child, step-child, child of the Employee's Civil Union Partner, legally adopted child (or child placed with the Employee in anticipation of adoption), eligible foster child, child for whom the Employee or spouse or Civil Union Partner is Legal Guardian, or a child for whom the Employee is required to provide coverage under a Qualified Medical Child Support Order.
4. An Employee's unmarried Child age 26 to 30, if the Child is an Illinois resident and has been discharged from service in the active or reserve components of the U.S. Armed Forces or National Guard.
5. An Employee's Child, age 26 or older, who is mentally or physically incapable of sustaining his or her own living, provided the child is unmarried and suffered such incapacity prior to attaining the otherwise limiting age.

The Dependent Eligibility section of the Plan sets out the requirements to establish that a Dependent is eligible for coverage as a Dependent under this Plan. The Plan reserves the right to require documentation, satisfactory to the

Plan Administrator, which establishes a Dependent relationship. "Dependent" does not include any person who is a member of the armed forces of any Country or who is a permanent resident of a Country outside the United States.

"Detoxification"
"Detoxification" shall mean the process whereby an alcohol-intoxicated person or person experiencing the symptoms of Substance Abuse is assisted, in a facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

"Diagnosis"
"Diagnosis" shall mean the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data.

"Diagnostic Service"
"Diagnostic Service" shall mean a test or procedure performed for specified symptoms to detect or to monitor a Disease or condition. It must be ordered by a Physician or other professional Provider.

"Disease"
"Disease" shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if either (1) evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an employee under any worker's compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, or (2) the individual is not covered under worker's compensation or similar law and is not required to have such coverage, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

"Durable Medical Equipment"
"Durable Medical Equipment" shall mean equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an Illness or Injury; and
4. Is appropriate for use in the home.

"Educational in Nature"
"Educational in Nature" shall mean the primary purpose of any drug, device, medical treatment or procedure is to provide the patient with any training in matters that are other than directly medical.

"Eligible Employee"
"Eligible Employee" shall mean the classes of Employees who are eligible for coverage under the Plan as set forth in the Eligibility for Coverage section of this document.

"Emergency"
"Emergency" shall mean a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

"Emergency Medical Condition"
"Emergency Medical Condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and

medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

"Emergency Services"
"Emergency Services" shall mean, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

"Essential Health Benefits"
"Essential Health Benefits" shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The Plan considers the following to be non-Essential Health Benefits:
1. Infertility (Assisted Reproductive Techniques);
2. Chiropractic care/skeletal adjustments; or
3. Beginning September 1, 2018, certain specialty drugs covered under the SaveonSP specialty Copay assistance program.

"Excess Charges"
"Excess Charge(s)" are the part of an expense for services, supplies and/or treatment of an Injury or Sickness that is in excess of the Reasonable and Allowable Amount.

"Experimental" and/or "Investigational"
"Experimental" and/or "Investigational" ("Experimental") shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials (except as provided herein) or under study to determine its:
    a. maximum tolerated dose;
    b. toxicity;

c. safety;
d. efficacy; and
e. efficacy as compared with the standard means of treatment or diagnosis; or

3. if reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
    a. maximum tolerated dose;
    b. toxicity;
    c. safety;
    d. efficacy; and
    e. efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Subject to a medical opinion, if no other FDA approved treatment is feasible and as a result the Participant faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment. The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

"Facility"
"Facility" shall mean a Facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, Rehabilitation Hospital, skilled nursing facility, community mental health center, dialysis center, residential treatment Facility, psychiatric treatment Facility, Substance Abuse Treatment Center, Birthing Center, Home Health Care Center, or any other such Facility that the Plan approves.

"Family Unit"
"Family Unit" shall mean the Employee, and his or her Dependents covered under the Plan.

"Final Internal Adverse Benefit Determination"
"Final Internal Adverse Benefit Determination" shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

"FMLA"
"FMLA" shall mean the Family and Medical Leave Act of 1993, as amended.

"FMLA Leave"
"FMLA Leave" shall mean a leave of absence, which the Participating Employer is required to extend to an Employee under the provisions of the FMLA.

"Genetic Testing"
"Genetic Testing" shall mean medical tests used to identify changes in chromosomes, genes or proteins.

"GINA"
"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

"HIPAA"
"HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

"Home Health Care"
"Home Health Care" shall mean the continual care and treatment of an individual if:

1. The institutionalization of the individual would otherwise have been required if home health care was not provided;
2. The treatment plan covering the home health care service is established and approved in writing by the attending Physician; and
3. The home health care is required as the result of an Illness or Injury.

"Home Health Care Agency"
"Home Health Care Agency" shall mean an agency or organization which provides a program of home health care and which:

1. Is approved as a Home Health Agency under Medicare;
2. Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
3. Meets all of the following requirements:
    a. It is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;
    b. It has a full-time administrator;
    c. It maintains written records of services provided to the patient;
    d. Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
    e. Its employees are bonded and it provides malpractice insurance.

"Hospice"
"Hospice" shall mean an agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements:

1. It has obtained any required state or governmental Certificate of Need approval;
2. It provides 24-hour-a-day, 7 days-a-week service;
3. It is under the direct supervision of a duly qualified Physician;
4. It has a nurse coordinator who is a registered nurse (R.N.) with 4 years of full-time clinical experience, at least 2 of which involved caring for terminally ill patients;
5. It has a social-service coordinator who is licensed in the jurisdiction in which it is located;
6. It is an agency that has as its primary purpose the provision of hospice services;
7. It has a full-time administrator;
8. It maintains written records of services provided to the patient;
9. Its employees are bonded and it provides malpractice and malpractice insurance;
10. It is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law;
11. It provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist or a certified respiratory therapist; and
12. It provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

"Hospital"
"Hospital" shall mean an Institution that meets all of the following requirements:

1. It provides medical and Surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;
2. It is under the supervision of a staff of Physicians;
3. It provides 24-hour-a-day nursing service by registered nurses;
4. It is duly licensed as a hospital, except that this requirement will not apply in the case of a State tax-supported Institution;
5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type Institution, or an Institution which is supported in whole or in part by a Federal government fund; and
6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

"Hospital" shall also have the same meaning, where appropriate in context, set forth in the definition of "Ambulatory Surgical Center."

"Hours of Service"
"Hours of Service" means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer and any hour for which the Employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R. 2530.2005-2(a)(i).

1. Vacation
2. Holiday
3. Illness or incapacity
4. Layoff
5. Jury duty
6. Military duty or leave of absence.

"Illness"
"Illness" shall have the meaning set forth in the definition of "Disease."

"Incurred"
A covered expense is "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, covered expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

"Injury"
"Injury" shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit, except as permitted by this Plan.

"Inpatient"
"Inpatient" shall mean any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for Room and Board is made by the Hospital.

"Institution"
"Institution" shall mean a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care Center, or any other such facility that the Plan approves.

"Intensive Care Unit"
"Intensive Care Unit" shall have the same meaning set forth in the definition of "Cardiac Care Unit."

"Leave of Absence"
"Leave of Absence" shall mean a leave of absence of an Employee that has been approved by his or her Participating Employer, as provided for in the Participating Employer's rules, policies, procedures and practices, up to a maximum of 12 months from the end of the month in which the Employee was last actively at work.

"Lifetime Maximum"
"Lifetime Maximum" shall mean the maximum benefit payable during an individual's lifetime while covered under this Plan. The Plan may provide a Lifetime Maximum benefit for specific types of medical treatment. The Lifetime Maximums will be shown in the applicable Schedule of Benefits.

"Long-Term Acute Care Facility/Hospital"
"Long-Term Acute Care Facility/Hospital" (LTACH) shall mean a Facility that provides specialized acute care for medically complex patients who are critically ill; have multi-system complications and/or failures and require hospitalization in a Facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour-a-day, 7 days a week basis. The severity of the LTACH patient's condition requires a Hospital stay that provides: (1) interactive Physician direction with daily on-site assessment; (2) significant ancillary services as dictated by complex, acute medical needs, such as full service and laboratory, radiology, respiratory care services, etc; (3) a patient-centered outcome-focused, interdisciplinary approach requiring a Physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care; (4) clinically competent care providers with advanced assessment and intervention skills; and (5) education for the patient and family to manage their present and future healthcare needs.

"Maintenance Therapy"
"Maintenance Therapy shall mean medical and non-medical health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient is not changing or does not require continued administration by medical personnel.

"Mastectomy"
"Mastectomy" shall mean the surgical removal of all or part of a breast.

"Medically Necessary"
"Medical Care Necessity", "Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, diagnosis or treatment of that Participant's Sickness or Injury. To be considered Medically Necessary, services must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. To be considered Medically Necessary services must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Participant's Sickness or Injury without adversely affecting the Participant's medical condition.

1. It must not be maintenance therapy or maintenance treatment.
2. Its purpose must be to restore health.

3. It must not be primarily custodial in nature.
4. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).
5. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all of these criteria must be met. Merely because a Physician recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Off-label Drug use is considered Medically Necessary when all of the following conditions are met:

1. The Drug is approved by the FDA;
2. The prescribed Drug use is supported by one of the following standard reference sources:
    a. DRUGDEX;
    b. The American Hospital Formulary Service Drug Information;
    c. Medicare approved Compendia; or
    d. Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the Drug is safe and effective for the specific condition; and
3. The Drug is Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

"Medicare"
"Medicare" shall mean the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

"Mental or Nervous Disorder"
"Mental or Nervous Disorder" shall mean any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources..

"Morbid Obesity"
"Morbid Obesity" is defined as (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction.

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

1. Name of an issuing State agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;

3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Network"
"Network" shall mean any medical Provider PPO Network the Plan contracts to access discounted fees for service for Participants. The Network will be identified on the identification card.

"No-Fault Auto Insurance"
"No-Fault Auto Insurance" is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

"Open Access Complete"
"Open Access Complete" shall mean the option in which the Plan uses the Reasonable and Allowable Amount to calculate payment for a Covered Expense to a medical Provider who does not participate in the Plan's PPO Network and does not otherwise have a contract with the Plan.

"Open Enrollment Period"
"Open Enrollment Period" shall mean August 1 through September 30 each year.

"Other Plan"
"Other Plan" shall include, but is not limited to, any of the following plans, other than this Plan, providing benefits or services for medical care or treatment:

1. Any primary payer besides the Plan;
2. Any other group health plan ;
3. Any other coverage or policy covering the Participant;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Worker's compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

"Out-of-Pocket Maximum"
"Out-of-Pocket Maximum" shall mean the maximum amount of deductible and coinsurance each Participant or family is responsible for paying during a calendar year before the coinsurance required by the Plan ceases to apply. When the applicable Out-of-Pocket Maximum is reached, the Plan will pay 100% of eligible covered expenses for the remainder of the calendar year. See the General Overview of the Plan section for details on what expenses are included in or excluded from the Out-of-Pocket Maximum. Refer to your Schedule of Benefits for the amount and the expenses that accumulate towards this maximum.

"Participant" / "Plan Participant"
"Participant" shall mean any Employee or retired Employee or Dependent who is eligible for benefits under the Plan.

"Physician"
"Physician" shall mean a legally licensed Physician who is acting within the scope of their license and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes, but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Speech Therapist, Speech

Pathologist and Licensed Midwife. An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

"Plan Administrator"
"Plan Administrator" shall mean the Plan Sponsor.

"Plan Sponsor"
"Plan Sponsor" shall mean the Board of Managers of the Egyptian Area Schools Employee Benefit Trust.

"Plan Year"
"Plan Year" shall mean the period from September 1 to August 31 of the following year.

"Pre-admission Tests"
"Pre-admission Tests" shall mean those Diagnostic Services done prior to scheduled Surgery, provided that:

1. The tests are approved by both the Hospital and the Physician;
2. The tests are performed on an outpatient basis prior to Hospital admission; and
3. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the Surgery.

"Preferred Provider Organization (PPO)"
"Preferred Provider Organization (PPO)" shall mean an organization that contracts with a Network of Providers offering services to Participants. Participants do not need to select a primary care Physician (PCP) and do not need referrals to see other Providers in the Network.

"Pregnancy"
"Pregnancy" shall mean carrying a child, resulting childbirth, miscarriage and non-elective abortion. The Plan considers Pregnancy as a Sickness for the purpose of determining benefits.

"Prescription Drug"
"Prescription Drug" shall mean injectable, insulin and prescription legend drugs or hypodermic needles or syringes. A prescription legend drug is a Federal legend drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription") or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law) and which, in either case, is legally obtained from a licensed drug dispenser only upon a prescription of a currently licensed Physician.

"Preventive Care"
"Preventive Care" shall mean certain Preventive Care services.

This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer coverage for certain preventive services without cost-sharing. To comply with the ACA, and in accordance with the recommendations and guidelines, the Plan will provide coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
3. Comprehensive guidelines for infants, Children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: https://www.uspreventiveservicestaskforce.org/ or at https://www.healthcare.gov/coverage/preventive-care-benefits/. For more information, contact the Third Party

Administrator or refer to the Preventive Care provisions in the Eligible Medical Expenses and Prescription Drug Card Program sections of this Plan.

"Prior to Effective Date" or "After Termination Date"
"Prior to Effective Date" or "After Termination Date" are dates occurring before a Participant gains coverage from the Plan, or dates occurring after a Participant loses coverage from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated.

"Privacy Standards"
"Privacy Standards" shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

"Provider"
"Provider" shall mean a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or health care facility defined or listed herein, or approved by the Plan Administrator.

"Psychiatric Hospital"
"Psychiatric Hospital" shall mean an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
3. It is licensed as a psychiatric hospital;
4. It requires that every patient be under the care of a Physician; and
5. It provides 24-hour-a-day nursing service.

The term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

"Qualified Medical Child Support Order" or "QMCSO"
"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan. A Medical Child Support Order is any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

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

"Reasonable and Allowable Amount"
"Reasonable and Allowed Amount" or "Reasonable and Allowable Amount" means the maximum amount payable by the Plan for a service, supply and/or treatment that is considered a Covered Expense. The Reasonable and Allowable Amount is the lesser of: 1) the charge made by the Provider that furnished the care, service, or supply; 2) the negotiated amount established by a discounting or negotiated arrangement; 3) the 'reasonable and customary charge' for the same treatment, service, or supply furnished in the same geographic area by a Provider of like service of similar training and experienced as further described below; or 4) an amount equivalent to the following:

1. For Inpatient or outpatient Facility claims, an amount equivalent to 140% of the Medicare equivalent allowable amount. This benefit level applies to Covered Expenses rendered by Hospitals and other facilities and to charges rendered by Providers billing as a Facility;
2. For PPO Network Provider claims, an amount equivalent to the negotiated rate for the Provider network;
3. For Open Access Complete Provider claims, an amount equivalent to the negotiated rate or 140% of the Medicare equivalent allowable amount; or
4. For specialty Drugs, the lesser of the average wholesale price (AWP) minus 14% or the amount set by the Plan's prescription Drug service vendor.

If there is insufficient information submitted for a given procedure, the Plan will determine the Reasonable and Allowed Amount based upon charges made for similar services. Determination of the reasonable and customary charge will take into consideration the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience, and the cost and quality data for that Provider.

The term 'geographic area' shall be defined as a metropolitan area, county, zip code, state or such greater area as is necessary to obtain a representative cross-section of Providers or Facilities as applicable, persons, or organizations rendering such treatment, service or supply for which a specific charge is made. For Covered Expenses rendered by a Physician, Hospital or Ancillary Provider in a geographic area where applicable law may dictate the maximum amount that can be billed by the rendering Provider or Facility, the Reasonable and Allowed Amount shall mean the lesser of amount established by applicable law for that Covered Expense or the amount determined as set forth above.

The Reasonable and Allowable Amount will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

The Plan Administrator or its designee has the *ultimate discretionary authority* to determine the Reasonable and Allowable Amount, including establishing the negotiated terms of a Provider arrangement as the Reasonable and Allowable Amount even if such negotiated terms do not satisfy the lesser of test described above.

"Rehabilitation Facility"
"Rehabilitation Facility" shall mean an Institution which mainly provides therapeutic and restorative services to Sick or Injured people. It is recognized as such if:

1. It carries out its stated purpose under all relevant Federal, State and local laws;
2. It is accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities or is approved for its stated purpose by Medicare; and
3. The confinement is not for Custodial Care or Maintenance Care.

"Room and Board"
"Room and Board" shall mean a Hospital's charge for:

1. Room and linen service;
2. Dietary service, including meals, special diets and nourishment;
3. General nursing service; and
4. Other conditions of occupancy which are Medically Necessary.

"Security Standards"
"Security Standards" shall mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

"Service Waiting Period"
"Service Waiting Period" shall mean an interval of time during which the Employee is in the continuous, Active Employment of his or her Participating Employer.

"Sickness"
"Sickness" shall have the meaning set forth in the definition of "Disease."

"Spinal Manipulation"
"Spinal Manipulation" shall mean skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

"Substance Abuse"
"Substance Abuse" shall mean any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as follows:

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

    1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);
    2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
    3. Craving or a strong desire or urge to use a substance; or
    4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

"Substance Abuse Treatment Center"
"Substance Abuse Treatment Center" shall mean an Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

"Substance Dependence"
"Substance Dependence" shall mean substance use history which includes the following: (1) Substance Abuse; (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

"Surgery"
"Surgery" shall mean any of the following:

1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. Obstetrical delivery and dilatation and curettage; or
7. Biopsy.

"Surgical Procedure"
"Surgical Procedure" shall have the same meaning set forth in the definition of "Surgery."

"Temporomandibular Joint Dysfunction Syndrome"
"Temporomandibular Joint Dysfunction Syndrome" (TMJ) shall mean a disease or symptoms of the jaw joint(s) and/or symptoms of the associated parts resulting in pain or the inability of the jaw to work properly. Associated parts of the jaw mean those functional parts that make the jaw work.

"Third Party Administrator"
"Third Party Administrator" shall mean HealthSCOPE Benefits, Inc., 27 Corporate Hill Drive, Little Rock, AR 72205.

"Total Disability" or "Totally Disabled"
"Total Disability" or "Totally Disabled" shall mean an individual is determined as being disabled as certified by Social Security, IMRF or TRS and provides such evidence to the Plan of the determination as the Plan Administrator may, in its sole discretion, require.

"Uniformed Services"
"Uniformed Services" shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

"USERRA"
"USERRA" shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ARTICLE VI
ELIGIBILITY FOR COVERAGE

6.01 Employee Eligibility

An eligible Employee who works on average 20 or more Hours of Service per week (or such minimum Hours of Service per week as may be required by the Participating Employer) will be eligible to enroll for coverage once he/she completes a service waiting period as designated by the Participating Employer from the date he or she completes at least one Hour of Service with the Participating Employer. Participation in the Plan will begin as determined by each Participating Employer following completion of the waiting period provided all required election and enrollment forms are properly submitted to the Participating Employer. A Retiree who immediately prior to retirement was considered an Employee and was covered under the Plan will also be considered an Eligible Employee.

An Employee shall be classified as one of the following:

1. **Certified Personnel:** a person required to have a teaching certificate for the position of employment that the person holds with the Employer;

2. **Educational Support Personnel:** a person not required to have a teaching certificate for the position of employment that the person holds with the Employer; or

3. **Retiree:** a former Employee (either Certified Personnel or Educational Support Personnel) who retired from employment as an eligible Employee of the Employer, was covered by the Plan (or the prior plan of the Employer) at the time of retirement and has maintained continuous coverage under the Plan (or the prior plan of the Employer) since retirement. A retired person will only qualify for coverage as a Retiree under the Plan if the person is eligible for a pension benefit or a disability pension benefit from either the Illinois Municipal Retirement Fund (IMRF) or the Teachers Retirement System (TRS), as determined by IMRF or TRS.

You are not eligible to participate in the Plan if you are an independent contractor, or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency).

Employee Eligibility During Approved Leave of Absence or Disability

An Employee who otherwise qualifies as an eligible Employee who is on an approved leave of absence under the leave policy of the Participating Employer will be considered an eligible Employee during the approved leave period up to a maximum of 12 months from the end of the month in which the Employee was last actively at work. Any period for which the Employee receives vacation pay or sick pay and any other period of paid or unpaid leave, including but not limited to FMLA leave and leave while receiving Workers' Compensation benefits, will be included in the maximum 12-month leave period. Except as provided in this paragraph, after 12 months of approved leave coverage may be continued only under the COBRA Continuation of Coverage section of the Plan up to the maximum coverage period. In this circumstance, the last day of the approved leave or the end of the first 12-month period, whichever occurs first, will be the first day of the COBRA continuation of coverage period. If an Employee is certified as disabled by Social Security, IMRF or TRS, the Employee will continue to be eligible as an Employee or Retiree during an approved leave of absence that exceeds 12 months as long as the disability continues and the individual otherwise continues to qualify as an eligible Employee or Retiree.

For more information related to the eligibility provisions that would qualify or disqualify you for this Plan, please contact your Participating Employer.

6.02 Dependent Eligibility

Your Dependent is eligible for participation in this Plan provided he/she is:

1. Your Spouse.

2. Your Civil Union Partner (as determined under Illinois law).

3. Your Child from birth until the end of the month in which he/she attains age 26.

4. Your unmarried Child age 26 to 30 if the child is an Illinois resident and has been discharged from service in the active or reserve components of the U.S. Armed Forces or National Guard.

5. Your Child age 26 or older, who is mentally or physically incapable of sustaining his or her own living, provided the child suffered such incapacity prior to the end of the month in which he/she attained age 26 or age 30. In this case your Child must be unmarried and primarily dependent upon you for support. The Plan Sponsor may require subsequent proof of your Child's disability and dependency, including a Physician's statement certifying your Child's physical or mental incapacity, within 31 days of the child's 26th or 30th birthday, as applicable, or within 31 days following your enrollment in the Plan in the case of a new Employee. Thereafter the Plan may require proof of incapacity at reasonable intervals.

6. A child for whom you are required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO).

These terms have the following meanings:

"Child" means your natural born child, stepchild, legally adopted child (or a child placed with you in anticipation of adoption), Eligible Foster Child or a child for whom you are the Legal Guardian. Coverage for an Eligible Foster Child or a child for whom you are the Legal Guardian will remain in effect until such child no longer meets the age requirements of an eligible Dependent under the terms of the Plan, regardless of whether or not such child has attained age 18 (or any other applicable age of emancipation of minors). The term "Child" shall include the children of your spouse or Civil Union Partner.

"Child placed with you in anticipation of adoption" means a child that you intend to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced. Also, a child for whom an Employee obtained legal custody by court order before the child reached age 18 will continue to be considered the child of the Employee after the child reaches age 18 and is no longer in legal custody provided the child otherwise meets the requirements to qualify as a Dependent child.

"Civil Union Partner" means an individual of the same or opposite sex registered under or recognized by Illinois law as the Employee's civil union partner. A domestic partnership or civil union that was legally entered into under the laws of another state is also recognized by Illinois as a civil union. The Employee will be required to submit an affidavit of civil union or other documentation issued under the applicable state law to the Participating Employer. A civil union partner after the civil union with the Employee has legally terminated will not be considered an eligible Dependent. The Plan Administrator reserves the right to require such evidence as it deems necessary that a Civil Union satisfies the above eligibility requirements.

"Eligible Foster Child" shall mean an individual who is placed with you by an authorized placement agency.

"Legal Guardian" means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual that is placed with such person by judgment, decree or other order of any court of competent jurisdiction.

"Spouse" means any person who is lawfully married to you under any state law, including a person of the same sex if you are legally married. The Plan Administrator may require documentation proving a legal marital relationship.

The Plan Administrator, in its sole discretion, shall have the right to require documentation necessary to establish any individual's status as an eligible Dependent.

Excluded as Dependents are:

1. a spouse legally separated or divorced from the Employee;
2. a civil union partner after the civil union with the Employee has legally terminated; and
3. any child, spouse or civil union partner while on active duty in any military service of any country.

Each Participating Employer is responsible for verifying that its Employees, Retirees and their Dependents satisfy the eligibility requirements to participate in the Plan. The Employer may be required to submit evidence of eligibility to the Third Party Administrator at any time.

When You and Your Spouse are both Covered Employees
If both an Employee and the Employee's Spouse or civil union partner are Employees of Employers participating in the Trust, each Spouse or partner may have separate coverage as an Employee. Either Spouse or partner may be covered as a Dependent of the other, or one or both may be covered as both an Employee and as a Dependent. An Employee may change from coverage as an Employee to coverage as a Dependent of his or her Spouse or partner, or from coverage as a Dependent to coverage as an Employee at any time, provided that there is not a lapse in coverage.

This Plan will coordinate benefits following the guidelines as described in the "Coordination of Benefits" section of the Plan.

Children may not be covered as Dependents of more than one Employee (or Retiree). A child may be covered under this Plan by only one Employee (or Retiree).

Court Ordered Coverage for a Child
Federal law requires the Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below.

The Employer shall enroll for immediate coverage under this Plan any Child who is the subject of a Qualified Medical Child Support Order" ("QMCSO"). If you are ordered to provide such coverage for a Child and you are not enrolled in the Plan at the time the Employer receives a QMCSO, the Employer shall also enroll you for immediate coverage under this Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Employer determines that the order is a QMCSO. Any required contribution for coverage pursuant to this section will be deducted from your pay in accordance with the Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your child and includes certain information concerning such coverage. The Employer will determine whether any child support order it receives qualifies as a QMCSO. Absent a QMCSO, no child is eligible for Plan coverage, even if you are required to provide coverage for that child under the terms of a separation agreement or court order, unless the child is an eligible Dependent Child under this Plan.

6.03 Retiree Eligibility

A former Employee is eligible for Retiree coverage if the individual:

1. Is a retired former Employee of the Employer;
2. Immediately prior to retirement, was considered an Employee and was covered under the Plan; and
3. Is eligible for a pension benefit or disability pension benefit from either the Illinois Municipal Retirement fund (IMRF) or the Teachers Retirement System (TRS), as determined by IMRF or TRS.

A Retiree's Spouse or Civil Union Partner and dependent children may continue coverage under the Retiree if they were covered under the Plan at the time the Employee retired. **Retirees and their eligible Dependents are not**

permitted to enroll in the Plan after retirement. A covered Retiree is not permitted to enroll new Dependents acquired after retirement.

If both a Retiree and the Retiree's Spouse or Civil Union Partner are covered as Retirees (or as an Employee in the case of the Spouse or partner) of Employers participating in the Trust, each Spouse or partner may be covered as a Dependent of the other, or one or both Spouses or partners may be covered as both a Retiree (or Employee) and as a Dependent. A Retiree may change from coverage as a Retiree to coverage as a Dependent, or from coverage as a Dependent back to coverage as a Retiree, provided that there is no lapse in coverage and provided further that the Employer from which the Retiree retired continues to participate in the Trust. A mere change in status without a lapse in coverage will not be considered as a late enrollment (which is not permitted for Retirees and Dependents of Retirees).

If you decide to enroll yourself and your eligible Dependents in Retiree coverage, you must enroll by completing all required enrollment forms and submitted them to your Employer within 31 days after your retirement date.

You are required to pay the cost of Retiree coverage for yourself and any eligible Dependents in accordance with the policies and procedures established by your Employer.

For further details regarding Retiree continuation of coverage options, refer to the COBRA Continuation of Coverage section of this document.

6.04 Timely Enrollment

Once you have completed any applicable waiting period as designated by your Participating Employer, and you and your eligible Dependents are eligible to participate in the Plan, you must enroll for coverage by completing all election and enrollment forms and submitting them to your Human Resources Department. You will have 31 days from the date first eligible to enroll for coverage. Coverage will become effective on the date you become eligible. In addition, as part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your Dependents. The Plan Administrator may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.

If you fail to complete and submit the appropriate election and enrollment forms described above, you will not be eligible to enroll in the Plan until the next open enrollment period or unless you experience a Special Enrollment Event or a Qualifying Change in Status.

If you enroll in the Plan you cannot drop coverage for yourself or any Dependent until the next annual open enrollment period unless you experience a Special Enrollment Event or a Qualifying Change in Status.

NOTE: If you transfer your employment from one Participating Employer to another Participating Employer, you must enroll with your new Employer within 31 days. Transfer of coverage in this case is not automatic. Also, because special rules apply in such cases, please contact your Human Resources Department or the Third Party Administrator/Claims Services Administrator for additional information.

Annual Open Enrollment

The Plan has one open enrollment period each year. The open enrollment period is from August 1 through September 30 each year, with an effective date of September 1 or October 1, as determined by each Participating Employer. You may add or drop coverage for yourself or your Dependents during the open enrollment period.

The coverage elections you make for yourself and your Dependents during the open enrollment period will be irrevocable for the next 12 months unless you have a Special Enrollment Event or a Qualifying Change in Status, as described later in this document. If you and/or your Dependents choose not to enroll in the Plan for the following year or when first eligible, you will not be permitted to enroll before the next open enrollment period unless you have a Special Enrollment Event or a Qualifying Change in Status. Conversely, if you elect coverage under the Plan, you

may not drop your coverage before the next open enrollment period unless you have a Special Enrollment Event or a Qualifying Change in Status.

Retired Employees and Dependents must be covered by the Plan at the time the Employee retires. Retirees and their Dependents are not permitted to enroll in the Plan after retirement. A covered Retiree is not permitted to enroll new dependents acquired after retirement.

6.05 Changing Plans

The Trust offers several benefit plan options with different Schedules of Benefits. Each Participating Employer will decide which plan option or options will be available to its Employees. An Employer may offer only one plan option or may offer up to 5 plan options at any time.

If your Employer offers more than one plan option, you must select and enroll in the plan option you want when you first enroll and during each open enrollment period. All covered family members must enroll in the same plan option. You cannot change between plan options outside of the open enrollment period, unless:

1. You have a Special Enrollment Event that allows you to add coverage for yourself or a Dependent during the year, or
2. Your Employer offers a new or different plan option as of January 1 of any year. In that case, Employees of your Employer will be permitted to enroll in or drop coverage for themselves and their eligible Dependents as of the January 1 effective date of the change in plan offerings.

6.06 Special Enrollment Events

The Plan provides special enrollment periods that allow Employees to enroll in the Plan, even if they declined enrollment during an initial or subsequent open enrollment period.

6.06A Loss of Other Coverage

If you declined enrollment for yourself or your Dependents because you and/or your Dependents had other health coverage, you may enroll for coverage under this Plan for yourself and/or your Dependents if you lose the other health coverage if you satisfy the conditions stated below. You must make written application for special enrollment within 31 days of the date of losing the other health coverage.

You may enroll during this special enrollment period if:

1. If the Employee is eligible for coverage under the terms of this Plan;
2. You (or a Dependent) are not currently enrolled under the Plan;
3. When enrollment was previously offered, you declined because of coverage under another group health plan or health insurance coverage. The Employee must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan; and
4. If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

An Employee who is already enrolled in the Plan may enroll in a different benefit plan option if a Dependent has a special enrollment right because the Dependent lost eligibility for other coverage. The Employee must make written application for special enrollment in the new plan option within 31 days of the date the other health coverage was lost.

You are not eligible for this special enrollment right if:

1. The other coverage was COBRA continuation coverage and you did not exhaust the maximum time available to you for that COBRA coverage; or

2. The other coverage was lost due to non-payment of requisite contribution / premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for the Employee and/or Dependent(s) will be effective the day following the date you submit the appropriate election and enrollment forms to your Employer.

6.06B Acquisition of a New Dependent

If you acquire a new Dependent as a result of marriage, civil union, domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll for coverage under this Plan for yourself and your Dependents during a special enrollment period if you satisfy the conditions below. You must make written application for special enrollment no later than 31 days after you acquire the new Dependent.

You may enroll yourself and/or your eligible Dependents during this special enrollment period if:

1. The Employee is eligible for coverage under the terms of this Plan; and
2. The Employee has acquired a new Dependent through marriage, civil union, domestic partnership, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied and you enroll timely, coverage for the Employee and Dependent(s*)* will be effective at 12:01 A.M.:

1. For a marriage, on the date of the marriage;
2. For domestic partnership or civil union, on the date of the domestic partnership agreement or registration as a civil union;
3. For a birth, on the date of birth; or
4. For an adoption or placement for adoption, on the date of birth if you are awarded physical or legal custody of a newborn child within 10 days of the date of birth. Otherwise, coverage for an adopted child will be effective as of the date of adoption or placement for adoption.

In the case of a newborn child, the time for enrolling the newborn (but not other family members) is extended, as follows:

1. Full Family or Employee Plus Child(ren) Coverage: If you are already enrolled and paying for full family coverage (Employee plus Spouse or civil union partner and at least one child) or Employee Plus Child(ren) coverage (Employee plus at least one child) your newborn child will be covered under your family coverage or Employee Plus Child(ren) coverage from birth. There is no time limit on enrolling the child in this case, but you must enroll the child before claims for the child can be considered.

2. Single or Employee Plus Spouse Coverage: If you are enrolled for single coverage or Employee plus Spouse or civil union partner coverage, you must enroll your newborn child within 90 days of birth or adoption and pay the additional premium to add the child. If you do not enroll your newborn within 90 days after birth, you will not be permitted to enroll the child until the next annual open enrollment period, unless you have another Qualifying Change in Status or Special Enrollment Event.

While you are allowed more than 31 days to enroll a newborn child, to take advantage of these Special Enrollment Rights to enroll yourself or other Dependents due to the birth of a child, you must enroll yourself and/or the other Dependents within 31 days of the birth.

6.06C Additional Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled also have special enrollment rights under the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (SCHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
2. The Employee or Dependent become eligible for a premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (SCHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

If you submit the appropriate election and enrollment forms to your Employer within 60 days after coverage under Medicaid or SCHIP terminates or after you qualify for a premium assistance subsidy, coverage under the Plan will become effective on the day following the date you submit the appropriate forms.

An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.

6.07 Qualifying Change in Status and Section 125 Plans

The Plan is structured to allow Participating Employers to maintain Section 125 Plans and to be compatible with the Section 125 Regulations of the Internal Revenue Code. In some cases, however, the Plan may allow changes in circumstances that may not be permitted under the Employer's Section 125 Plan. It is the Employer's responsibility to determine whether a change is permitted under the Employer's Section 125 Plan, if applicable.

Generally your election under the Plan will remain in effect for the entire Plan Year unless you experience a Special Enrollment Event or a Qualifying Change in Status. If a Qualifying Change in Status occurs you may make a new election under the Plan provided your new election is consistent with the Qualifying Change in Status. You must submit the appropriate election and enrollment forms to your Employer's Human Resources Department within 31 days after the Qualifying Change in Status along with written proof of the event, except when a longer notice period is permitted under the Special Enrollment Event rules in the preceding section.

A Qualifying Change in Status includes the following:

1. A change in your legal marital status, including divorce, legal separation, annulment or entering into a civil union.

2. The death of your Spouse, Dependent Child or civil union partner.

3. Termination of a civil union.

4. Termination or commencement of employment by you, your Spouse or your Dependent Child that results in the gain or loss of eligibility under the Plan or another employer-sponsored employee medical benefit plan, including a strike or lockout.

5. A reduction or increase in your hours of employment or those of your Spouse, civil union partner or your Dependent Child, including a switch from part-time to full-time or commencement or return from an unpaid leave of absence, resulting in the gain or loss of eligibility under the Plan or another employer-sponsored employee medical benefit plan.

6. Your Dependent Child satisfying or ceasing to satisfy the requirements for Dependents under the Plan.

7. A change in the place of residence or work of you, your Spouse or your Dependent Child.

8. The annual TRS insurance plan open enrollment period for Retirees and their eligible Dependents.

9. Entitlement to or loss of entitlement to Medicare or Medicaid by you, your Spouse or your Dependent Child.

10. Receipt of a Qualified Medical Child Support Order ("QMCSO") which requires that you provide the child named in the Order with health care coverage under the Plan. If the required coverage is different from your current coverage under the Plan, you may change your election accordingly.

11. A change due to you, your Spouse, civil union partner or your Dependent Child gaining coverage under another employer's plan.

12. Change in Cost of Coverage or New Plan Option. If the cost of coverage increases or decreases during a Plan Year, the Employer may, in accordance with plan terms, automatically change the Participant's contribution. If permitted by the Section 125 plan, when the change in cost is significant, the Participant may elect to increase his/her contribution or elect less costly coverage. When a new plan option is added, the Participant may change his/her election to the new option.

13. Change in Election under another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including a plan maintained by the employer of your Spouse or Dependent Child) provided the election change satisfied the regulations under Code Section 125 regarding permitted election changes or the election is for a period of coverage under the plan maintained by the other employer which does not correspond to the Plan Year of this Plan.

14. Insurance Marketplace Annual Open Enrollment Periods. The insurance marketplace offers annual open enrollment periods for coverage effective January 1 each year. A Participant who elects to enroll for coverage through the insurance marketplace during the marketplace annual open enrollment period will be permitted to drop Plan coverage as of December 31. An Employee who was previously enrolled for coverage through the marketplace will be permitted to drop that coverage and enroll in this Plan effective January 1. The Employer will be responsible for confirming that the decision to enroll in or drop coverage through this Plan corresponds to the Participant's decision to drop or add coverage purchased through the marketplace.

15. Insurance Marketplace Special Enrollment Periods. If you have a mid-year special enrollment opportunity to enroll for coverage through the insurance marketplace you may cancel your coverage under this Plan, but only if you (and all Dependents whose coverage is being cancelled) enroll for health insurance through the marketplace (or other private health insurance) with an effective date no later than the next day after coverage under this Plan terminates. The Employer will be responsible for confirming that the decision to drop coverage through this Plan corresponds to enrollment in other insurance. The Employer may rely on a signed statement from you specifying the special enrollment event and confirming that all Participants whose coverage is being canceled have enrolled in or will enroll in other health insurance coverage by the stated deadline. The Employer may also require additional documentation of the other coverage. If you pay for coverage through a Section 125 cafeteria plan you may not be able to change your election under the Section 125 plan unless you enroll in coverage through the marketplace. Enrollment in other health insurance generally will not qualify to make changes under a Section 125 plan.

You must submit the appropriate election and enrollment forms to your Human Resources Department within 31 days after the Qualifying Change in Status, except where a longer election period is permitted under the Special Enrollment Event rules.

A Change in Status does not allow you to change to a different Plan option outside the annual open enrollment period, except as specified above under the Changing Plans section.

6.08 Reinstatement After Lapse in Coverage Due to Approved Family or Medical Leave of Absence

The normal rules that preclude mid-year enrollment are waived for any Employee and eligible Dependents who were previously covered under the Plan and resume coverage following a brief lapse in coverage, provided that ALL of the following requirements are satisfied:

1. Coverage lapsed during a period the Employee was on an approved leave of absence from the Employer;

2. The reason for the leave is a reason that would qualify as family or medical leave under the Family and Leave Act (FMLA) (whether or not the Employee is actually entitled to leave under the FMLA); and
3. The lapse in coverage does not exceed the shorter of the actual period of leave taken by the Employee or 12 weeks (26 weeks for military caregiver leave).

Under the FMLA a leave of absence may be taken for any one of the following reasons:

1. the birth of a child of the Employee;
2. placement of a child with the Employee for adoption or foster care;
3. a serious health condition that makes the Employee unable to perform his or her job;
4. to permit the Employee to care for a spouse or civil union partner, a child or parent if the family member has a serious health condition;
5. "qualifying exigency leave" if the Employee's spouse or civil union partner, child or parent (i) is a retired member of the Armed Forces or Reserves or in the Reserves or National Guard and (ii) is on active duty or ordered to active duty in the U.S. Armed Forces in support of a contingency operation (as designated by the Secretary of Defense and stated in the service member's active duty orders) to permit the Employee to make childcare, legal or financial arrangements or for other activities prescribed in the FMLA regulations; or
6. "military caregiver leave" to permit the Employee to care for a spouse or civil union partner, child, parent or next of kin who is a current member of the Armed Forces or National Guard or Reserves who has a serious injury or illness incurred in the line of active duty for which the service member is undergoing outpatient medical treatment, recuperation or therapy.

6.00 Qualified Medical Child Support Orders

The Employer shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Qualified Medical Child Support Order QMCSO if such an individual is not already covered by the Plan as an Eligible Dependent, once the Employer has determined that such order meets the standards for qualification set forth below.

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

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

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

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

1. Name of an issuing State child support enforcement agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan or eligible for enrollment;
3. Name and mailing address each of the Alternate Recipients (i.e., the child or children of the Participant or the name and address of a State or local office may be substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";
2. Identifies either the specific type of coverage or all available group health coverage;
3. Informs the Plan Administrator that if the NMSN does not designate either specific types of coverage or all available coverage, the Administrator should assume that all are designated, and further informs the Plan Administrator that if the plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and
4. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to eligible Participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

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

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Employer shall:

1. Notify the State agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
    a. Whether the child is covered under the Plan; and
    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall assist the Employer to:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

6.10"GINA"
"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment.

ARTICLE VII
TERMINATION OF COVERAGE

7.01 Termination Dates of Employee Coverage

Coverage of any Employee under this Plan will terminate on the earliest to occur of the following dates:

1. The date the Plan terminates;
2. The date your Employer ceases to be a Participating Employer;
3. The last day of the month for which you last made a contribution if you fail to make a required contribution when due;
4. The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained under the Continuation of Coverage and USERRA section;
5. The last day of the month in which you cease to be eligible for coverage under the Plan;
6. The date coverage or certain benefits are terminated for your particular class by modification of the Plan;
7. The last day of the month in which your employment with a Participating Employer ends, unless you are eligible and enroll for coverage as a Retiree;
8. The last day of the 12th full month following the month in which you were last actively at work if your approved leave of absence extends beyond 12 months and you have not been certified as disabled by Social Security, IMRF or TRS; or
9. The date you or your Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

7.02 Termination Dates of Retiree Coverage

Coverage of any Retiree under the Plan will terminate on the earliest to occur of the following dates:

1. The date the Plan terminates or no longer provides Retiree coverage;
2. The date your former Employer ceases to be a Participating Employer;
3. The date you cease to qualify as a Retiree, unless you are eligible and re-enroll for coverage as an Employee;
4. The last day of the month for which you last made a contribution if you fail to make a required contribution when due;
5. The date of your death;
6. The date you or your Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Retirees and their Dependents must be covered by the Plan at the time the Employee retires. Retirees and their Dependents are not permitted to enroll in the Plan after retirement. When a Retiree terminates Retiree coverage under this Plan, the Retiree is not allowed to re-enroll at a later date as a Retiree.

7.03 Termination Dates of Dependent Coverage

Coverage for the covered Dependents of an Employee or Retiree will terminate on the earliest to occur of the following dates:

1. The date the Plan terminates;
2. The date the Plan discontinues coverage for Dependents;
3. The date the Employee's or Retiree's coverage under the Plan terminates for any reason except death;
4. The last day of the month for which the Employee or Dependent last made a contribution if any required contribution is not paid when due;
5. The date the Dependent spouse or civil union partner reports to active military service;
6. The last day of the month in which a Dependent spouse or civil union partner ceases to be a Dependent as defined by the Plan, including by reason of legal separation or divorce, or legal termination of a civil union;

7. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
    a. Cessation of such inability;
    b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
    c. Upon the Child's no longer being dependent on the Employee or Retiree for support;
8. The last day of the month in which a Dependent Child ceases to qualify as a Dependent of the Employee or Retiree;
9. The date the Employee or Retiree or Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

7.03A Surviving Dependents

In the event of death of an Employee or Retiree, coverage will continue for the Spouse, civil union partner, and/or other eligible Dependents who were covered at the time of the death, provided the Employer of the decedent remains a Participating Employer in the Trust, until the earliest of the following:

1. The date such spouse or civil union partner remarries or enters into a civil union;
2. The date a required contribution has not been paid;
3. The date a Dependent child becomes eligible for Medicare;
4. The date the Dependent fails to satisfy the eligibility requirements for Dependent coverage under the Plan.

If any eligible surviving Dependents decide to continue their coverage under the Plan, they must enroll by completing all required election and enrollment forms and submitting them to their Employer's Human Resources Department within 31 days after the date of the Employee's/Retiree's death. Participation in the Plan will continue for the surviving spouse/civil union partner/Dependent as of the date of the death, provided all required election and enrollment forms are properly submitted to your Human Resources Department. The cost of Plan coverage under this survivor benefit will be communicated to the Participant by the Employer.

7.04 Continuation of Coverage

When coverage terminates under the provisions of the section, an individual may nevertheless be eligible to continue coverage under the circumstances described in the next Article, Continuation of Coverage.

7.05 Retroactive Termination of Coverage

Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

7.06 Suspension of Claims

If your coverage terminates due to the withdrawal of your Employer as a Participating Employer in the Plan, and if your Employer fails to make all required contributions and withdrawal payments to the Trust, your claims must be suspended and payment will not be made until your Employer has satisfied its obligations to the Plan and Trust. If your Employer fails to satisfy its obligation to the Trust, the Employer will be responsible for any pending claims you or your dependents may have.

ARTICLE VIII
CONTINUATION OF COVERAGE – FMLA, USERRA AND COBRA

8.01 Continuation During FMLA Leave

The Plan shall at all times comply with FMLA. During any leave taken under FMLA, the Employee will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

The Family and Medical Leave Act is a Federal law that applies, generally, to employers with 50 or more Employees, and provides that an eligible Employee may elect to continue coverage under this Plan during a period of approved FMLA Leave at the same cost as if the leave had not been taken.

If provisions under the Plan change while an Employee is on FMLA Leave, the changes will be effective for him or her on the same date as they would have been had he or she not taken leave.

This section generally states the basic FMLA rules. Each Participating Employee is responsible for administering FMLA, when applicable, in accordance with the Employer's specific leave policies and applicable law.

8.01A Eligible Employees

Employees are eligible for FMLA Leave if all of the following conditions are met:

1. The Employee has been employed with the Employer for at least 12 months;
2. The Employee has been employed with the Employer at least 1,250 hours during the 12 consecutive months prior to the request for FMLA Leave; and
3. The Employee is employed at a worksite that employs at least 50 employees within a 75-mile radius.

8.01B Qualifying Circumstances for FMLA Leave

Coverage under FMLA Leave is limited to a total of 12 workweeks during any 12-month period that follows:

1. The birth of, and to care for, a Son or Daughter;
2. The placement of a Child with the Employee for adoption or foster care;
3. The Employee's taking leave to care for his or her Spouse, Son or Daughter, or Parent who has a Serious Health Condition;
4. The Employee's taking leave due to a Serious Health Condition which makes him or her unable to perform the functions of his or her position; or
5. A Qualifying Exigency arising out of the fact that a Spouse, Son, Daughter, or Parent of the Employee is a member of a regular or reserve component of the Armed Forces and is on (or has been notified of impending call to) covered active duty.

Coverage under FMLA Leave is limited to a total of 26 workweeks during any 12-month period for the following situations:

1. To care for a covered service member following a Serious Illness or Injury to that covered service member, when the Employee is that service member's Spouse, Son or Daughter, Parent, or Next of Kin; or
2. To care for a veteran who is undergoing medical treatment, recuperation, or therapy for a Serious Illness or Injury that occurred any time during the five years preceding the date of treatment, when the Employee is that veteran's Spouse, Son or Daughter, Parent, or Next of Kin.

***The FMLA definitions of "serious Injury or Illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".**

This leave may be considered as a paid (accrued vacation time, personal leave or family or sick leave, as applicable) or unpaid leave. The Employer has the right to require that all paid leave be used prior to providing any unpaid leave.

An Employee must continue to pay his or her portion of the Plan contribution, if any, during the FMLA Leave. Payment must be made within 30 days of the due date established by the Employer. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

8.01C Notice Requirements

An Employee must provide at least 30 days' notice to his or her Employer prior to beginning any leave under FMLA. If the nature of the leave does not permit such notice, the Employee must provide notice of the leave as soon as possible. The Employer has the right to require medical certification to support the Employee's request for leave due to a Serious Health Condition for the Employee or his or her eligible family members.

8.01D Length of Leave

During any one 12-month period, the maximum amount of FMLA Leave may not exceed 12 workweeks for most FMLA related situations. The maximum periods for an Employee who is the primary care giver of a service member with a Serious Illness or Injury that was Incurred in the line of active duty may take up to 26 weeks of FMLA Leave in a single 12-month period to care for that service member. The Employer may use any of four methods for determining this 12-month period.

If the Employee and his or her Spouse are both employed by the Employer, FMLA Leave may be limited to a combined period of 12 workweeks, for both Spouses, when FMLA Leave is due to:

1. The birth or placement for adoption or foster care of a Child; or
2. The need to care for a Parent who has a Serious Health Condition.

8.01E Termination of FMLA Leave

Coverage may end before the maximum 12-week (or 26-week) period under the following circumstances:

1. When the Employee informs his or her Employer of his or her intent not to return from leave;
2. When the employment relationship would have terminated but for the leave (such as during a reduction in force);
3. When the Employee fails to return from the leave;
4. If any required Plan contribution is not paid within 30 days of its due date;
5. The Employer is advised and/or determines that no FMLA Qualifying Circumstance occurred.

If an Employee does not return to work when coverage under FMLA Leave ends, the Employee will be eligible for *COBRA* continuation of coverage at that time, in accordance with the parameters set forth by this Plan and applicable law. An Employee may also be eligible for coverage during a leave longer than required by FMLA under the Employer's leave policies and the rules stated in section 6.01 above.

8.01F Recovery of Plan Contributions

The Participating Employer has the right to recover any portion of the Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA Leave if an Employee does not return to work at the end of the leave. This right will not apply if failure to return is due to the continuation, recurrence or onset of a Serious Health Condition that entitles the Employee to FMLA Leave (in which case the Employer may require medical certification) or other circumstances beyond the Employee's control.

8.01G Reinstatement of Coverage
The law requires that coverage be reinstated upon the Employee's return to work following an FMLA Leave whether or not the Employee maintained coverage under the Plan during the FMLA Leave.

On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA Leave had not been taken. Any Service Waiting Period will be credited as if the Employee had been continually covered under the Plan.

8.01H Definitions
For the FMLA Leave provisions only, the following terms are defined as stated.

"Next of Kin"
"Next of Kin" shall mean the nearest blood relative to the service member.

"Parent"
"Parent" shall mean the Employee's biological parent or someone who has acted as his or her parent in place of his or her biological parent when he or she was a Son or Daughter.

"Qualifying Exigency"
"Qualifying Exigency" shall mean:

1. Short-notice deployment.
   a. To address any issue that arises from the fact that a covered military member is notified seven or less calendar days prior to the date of deployment of an impending call or order to active duty in support of a contingency operation; and
   b. Leave taken for this purpose can be used for a period of seven calendar days beginning on the date a covered military member is notified of an impending call or order to active duty in support of a contingency operation.

2. Military events and related activities.
   a. To attend any official ceremony, program, or event sponsored by the military that is related to the active duty or call to active duty status of a covered military member; and
   b. To attend family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross that are related to the active duty or call to active duty status of a covered military member.

3. Childcare and school activities.
   a. To arrange for alternative childcare when the active duty or call to active duty status of a covered military member necessitates a change in the existing childcare arrangement for a biological, adopted, or foster Child, a stepchild, or a legal ward of a covered military member, or a Child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence;
   b. To provide childcare on an urgent, immediate need basis (but not on a routine, regular, or everyday basis) when the need to provide such care arises from the active duty or call to active duty status of a covered military member for a biological, adopted, or foster Child, a stepchild, or a legal ward of a covered military member, or a Child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence;
   c. To enroll in or transfer to a new school or daycare facility, a biological, adopted, or foster Child, a stepchild, or a legal ward of the covered military member, or a Child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence, when

enrollment or transfer is necessitated by the active duty or call to active duty status of a covered military member; and

d. To attend meetings with staff at a school or a daycare facility, such as meetings with school officials regarding disciplinary measures, parent-teacher conferences, or meetings with school counselors, for a biological, adopted, or foster Child, a stepchild, or a legal ward of the covered military member, or a Child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence, when such meetings are necessary due to circumstances arising from the active duty or call to active duty status of a covered military member.

4. Financial and legal arrangements.
   a. To make or update financial or legal arrangements to address the covered military member's absence while on active duty or call to active duty status, such as preparing and executing financial and healthcare powers of attorney, transferring bank account signature authority, enrolling in the Defense Enrollment Eligibility Reporting System (DEERS), obtaining military identification cards, or preparing or updating a will or living trust; and
   b. To act as the covered military member's representative before a Federal, State, or local agency for purposes of obtaining, arranging, or appealing military service benefits while the covered military member is on active duty or call to active duty status, and for a period of 90 days following the termination of the covered military member's active duty status.

5. Counseling. To attend counseling provided by someone other than a health care Provider for oneself, for the covered military member, or for the biological, adopted, or foster Child, a stepchild, or a legal ward of the covered military member, or a Child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence, provided that the need for counseling arises from the active duty or call to active duty status of a covered military member.

6. Rest and recuperation. To spend time with a covered military member who is on short-term, temporary, rest and recuperation leave during the period of deployment. Eligible Employees may take up to five days of leave for each instance of rest and recuperation if permitted under the Employer's FMLA policy.

7. Post-deployment activities.
   a. To attend arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of 90 days following the termination of the covered military member's active duty status; and
   b. To address issues that arise from the death of a covered military member while on active duty status, such as meeting and recovering the body of the covered military member and making funeral arrangements.

8. Additional activities. To address other events which arise out of the covered military member's active duty or call to active duty status provided that the Participating Employer and Employee agree that such leave shall qualify as an exigency, and agree to both the timing and duration of such leave.

"Serious Health Condition"

"Serious Health Condition" shall mean an Illness, Injury, impairment, or physical or mental condition that involves:

1. Inpatient care in a Hospital, hospice, or residential medical facility; or
2. Continuing treatment by a health care Provider (a doctor of medicine or osteopathy who is authorized to practice medicine or Surgery, as appropriate, by the State in which the doctor practices, or any other person determined by the Secretary of Labor to be capable of providing health care services).

"Serious Illness or Injury (of a service member or covered veteran)"

"Serious Illness or Injury" shall mean an Illness or Injury Incurred in the line of duty that may render the service member medically unfit to perform his or her military duties. A serious Injury or Illness for a current service member includes an Injury or Illness that existed before the beginning of the service member's active duty and was aggravated by service in the line of duty on active duty in the armed forces. A serious Injury or Illness for a covered veteran means an Injury or Illness that was Incurred or aggravated by the service member in the line of duty on active duty in the armed forces and manifested itself before or after the service member became a veteran.

"Son or Daughter"
"Son or Daughter" shall mean the Employee's biological child, adopted child, stepchild, foster child, a child placed in the Employee's legal custody, or a child for which the Employee is acting as the parent in place of the child's natural blood related parent.

"Spouse"
"Spouse" shall mean an Employee's husband or wife.

NOTE: For complete information regarding FMLA rights, contact your Employer.

8.02 Continuation During Military Leave (USERRA)

An Employee who is absent from employment due to military service in the Uniformed Services has a right under the Uniformed Services Employment and Reemployment Rights Act (USERRA) to elect to continue coverage under this Plan for up to 24 months for the Employee and any Dependents who were covered at the time the leave began. To continue coverage under USERRA, you must submit your election to continue coverage to your Human Resources Department within 60 days after the date your leave begins. If elected timely, coverage will be effective as of the date of your leave and will continue for the lesser of (a) 24 months (beginning on the date your absence begins); or (b) the period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Participating Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA. If your military service is 31 days or more, you will be required to pay up to 102% of the full contribution under the Plan. If your leave is 30 days or less, you will not be required to pay more than the amount (if any) you would have paid had you remained an active Employee of your Employer.

USERRA also requires that, regardless of whether you elect to continue coverage under the Plan during your military service, your coverage and coverage for your eligible Dependents coverage must be reinstated immediately upon your return to employment, so long as you meet certain requirements contained in USERRA. Contact your Employer for information concerning your eligibility for USERRA and any requirements of the Plan.

8.03 COBRA Continuation Coverage

The right to COBRA Continuation Coverage was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a "qualifying event".

This section is intended only to summarize your rights and obligations under the law. The law, however, is not clear on some points and is interpreted by Federal agencies and the courts. Therefore, this summary is subject to change without notice as interpretations or changes of the law occur. Both you and your Spouse or civil union partner should read this summary carefully and keep it with your records.

Before electing COBRA coverage you should also consider other options available when your Plan coverage terminates. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace you may qualify for lower premium costs and/or lower out of pocket costs. In addition, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan) even if that plan generally does not accept late enrollees.

8.03A Qualified Beneficiaries

In general, you, your Spouse and any Dependent Child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan are considered "qualified beneficiaries" who are eligible to elect COBRA continuation coverage.

In addition, any Dependent Child who is born to or placed for adoption with you during a period of COBRA continuation coverage is considered a "qualified beneficiary".

A civil union partner of an Employee generally is not entitled to continue coverage under COBRA; however the Trust has chosen to extend COBRA-like coverage to civil union partners and children of a civil union partner. This COBRA-like coverage is identical to the COBRA continuation of coverage offered to a Spouse or Dependent child of an Employee.

Each qualified beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

8.03B Qualifying Events

Continuation for Up to 18 Months

If you are a covered Employee, you, your Spouse or civil union partner and/or Dependent Child will become a qualified beneficiary if you lose your coverage under the Plan because of either one of the following qualifying events:

1. Your hours of employment are reduced below the minimum required to maintain eligibility; or
2. Your employment ends for any reason other than your gross misconduct.

You, your Spouse or civil union partner and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 18 months provided you elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage.

You, your Spouse or civil union partner and Dependent Child have an independent right to elect COBRA Continuation Coverage. You and/or your Spouse or civil union partner may elect coverage on behalf of either one of you and parents may elect coverage on behalf of their Dependent Child.

Continuation for up to 36 Months

If you are the Spouse or civil union partner and/or Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:

1. The spouse/parent-Employee dies;
2. The spouse/parent-Employee becomes entitled to Medicare benefits (under Part A, Part B or both);
3. The Employee and spouse/parent become divorced or legally separated or a civil union is terminated; or
4. A Dependent Child ceases to meet the requirements to qualify as a Dependent Child under this Plan.

Your Spouse or civil union partner and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 36 months provided such Spouse or civil union partner and/or Dependent Child provide notice of the qualifying event to your Human Resources Department and elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA Continuation Coverage and their obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

NOTE: Under this Plan Dependents generally do not lose coverage if the Employee dies, Employees and their Dependents generally do not lose coverage if the Employee retires and receives a pension from IMRF or TRS, and

Retirees and Employees generally do not lose coverage when they become eligible for Medicare. In cases where the event does not cause loss of coverage, Employees and their Dependents do not need to elect COBRA continuation coverage. However, the Employee's death, retirement or eligibility for Medicare will be considered a COBRA qualifying event for purposes of measuring the period during which the Employee's Dependents retain COBRA rights. If another event occurs that causes the Dependents to lose coverage under the Plan, all coverage from the date of the initial COBRA qualifying event will be counted in determining the maximum COBRA coverage period. For example, if an Employee or Retiree decides to drop Plan coverage due to Medicare eligibility or eligibility for medical benefits under TRS or IMRF, Dependents of the Employee or Retiree will lose their coverage. The Dependents may elect continuation coverage under these COBRA rules for any remaining portion of the COBRA coverage period if the loss of regular coverage occurs within the maximum COBRA coverage period, measured from the date of the applicable initial qualifying event (death of the Employee or retirement/termination of employment or eligibility for Medicare). Dependents whose coverage has been continued under the terms of the Plan beyond the maximum COBRA coverage period, measured from the date of the initial qualifying event, may not elect continuation coverage under these COBRA rules**.**

Extension of 18-Month Continuation Coverage Period

Disability Extension. If you, your Spouse or civil union partner or Dependent Child is determined to be disabled by the Social Security Act (SSA); you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to your Human Resources Department within 60 days after the later of (a) the date of the SSA determination; (b) the date coverage under the Plan would end due to the qualifying event; or (c) the date you are given notice of your obligation to provide such notice. In any event, notice must be given to your Human Resources Department prior to the end of the initial 18-month period of coverage. If you are later determined not disabled by SSA, you must notify your Human Resources Department within 30 days following the later of (a) the date of the SSA determination; or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Second Qualifying Event Extension. If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse or civil union partner and any Dependent Child in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. To qualify for this extension in coverage, notification must be given to your Human Resources Department within 60 days after the later of (a) the date coverage under the Plan would end due to the qualifying event or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

8.03C Notice Requirement

The Employee or a family member has the responsibility to notify the Employer of a divorce, legal separation, termination of a civil union or a child losing dependent status under the Plan. You or your family member must give this notice no later than 60 days after the date of the applicable event. **If you fail to give this notice during the 60-day period, you will not be offered the option to elect continuation coverage.**

When the Employer is notified that one of these events has happened, the Employer must notify the Third Party Administrator. The Employer must also notify the Third Party Administrator if one of the following events occurs and results in a loss of coverage: the Employee's retirement or other termination of employment, reduction in hours, or death, or the Employee becoming entitled to Medicare. The Third Party Administrator will then notify you in writing that you have the right to elect continuation coverage.

You must elect continuation coverage within 60 days after your regular Plan coverage ends, or, if later, within 60 days after you are notified of your right to elect continuation coverage. If you do not elect continuation coverage within this 60-day period, you will lose your right to elect continuation coverage.

The notice must be postmarked (if mailed) or received by the Third Party Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan or if you are eligible for an extension of COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

For qualifying events such as divorce or legal separation of the Employee and Spouse, termination of a civil union, or a Dependent Child's loss of eligibility under the Plan, the notice must contain the following information:

1. Name and address of the covered Employee or former employee;
2. Name and address of your Spouse, former Spouse or civil union partner and any Dependent Children;
3. Description of the qualifying event; and
4. Date of the qualifying event.

In addition to the information above, if you, your Spouse or any Dependent Child is determined by SSA to be disabled within 60 days after your COBRA continuation coverage begins, the notice must also contain the following information:

1. Name of person deemed disabled;
2. Date of disability determination; and
3. Copy of SSA determination letter.

If you cannot provide a copy of the decree of divorce or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage or extension of such coverage, will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the Third Party Administrator may request additional information. If the individual fails to provide such information within the time period specified in the request, the notice may be rejected.

In addition to accepting a letter with the information described above, the Third Party Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse or civil union partner may obtain a copy by requesting it from the Third Party Administrator at the address provided in this notice.

Notice must be sent to the Third Party Administrator at:

HealthSCOPE Benefits
P.O. Box 2459
Little Rock, AR 72203

8.03D Payment for COBRA Continuation Coverage

If you elect continuation coverage, the Plan must provide coverage that, as of the time coverage is provided, is identical to the coverage provided under the Plan to similarly situated Employees or family members. If the coverage for similarly situated Employees or family members is modified, your coverage will be modified.

You must pay the premium payment for your "initial premium month" and subsequent months to bring your payments current, by the 45th day after you elect continuation coverage. Your initial premium month is the first month after your regular Plan coverage terminates. All future premiums are due on the 1st of the month for which the premium is due, subject to a 30 day grace period.

COBRA premium rates will be determined as follows:

1. Employee only: Employee rate plus 2% administration charge;
2. Employee and Spouse/Partner: Employee + Spouse/Partner rate plus 2%;
3. Employee and Child or Children: Employee + Child or Children rate plus 2%;
4. Employee and Spouse/Partner and One or More Children: Family rate plus 2%;
5. Spouse/Partner only: Difference between Employee + Spouse/Partner rate and Employee rate plus 2%;
6. One or More Children: Difference between Employee + Child or Children rate and Employee rate plus 2%;
7. Spouse/Partner and One or More Children: Difference between Family rate and Employee rate plus 2%.

8.03E Termination of COBRA Continuation Coverage

COBRA continuation coverage automatically ends 18, 29 or 36 months (whichever is applicable) after the date of the qualifying event; however COBRA coverage under this Plan may end before the end of the maximum period on the earliest of the following events:

1. The date your Employer withdraws from the Trust or ceases to provide any group health plan coverage.
2. The date on which the qualified beneficiary fails to pay the required contribution.
3. The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise) or entitled to either Medicare Part A or Part B (whichever comes first).
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

8.03F Additional Information

Additional information about the Plan and COBRA continuation coverage is available from your Employer or the Third Party Administrator identified above and in the General Plan Information section of this Plan.

If your marital status or civil union status changes, or a Dependent ceases to be a Dependent eligible for coverage under the Plan terms, you must immediately notify your Employer.

You should also keep your Employer and the Third Party Administrator informed of any changes in the addresses of covered family members.

ARTICLE IX
PLAN ADMINISTRATION

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

9.01 Plan Administrator

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

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

9.02 Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

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

9.03 Amending and Terminating the Plan

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

Any Participating Employer may terminate its participation in the Plan and thereby terminate the coverage of its eligible Employees, Retirees and their Dependents under this Plan.

If the Plan is terminated, of if an Employer terminates its participation in the Plan, the rights of the affected Participants are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

9.04 Final Authority of the Plan Document

The terms and provisions contained in this Plan Document and Summary Plan Description shall be final and binding upon all Participants. Contradictory benefit information received from any other source will not affect the terms of the Plan as set forth herein. Participants are advised to conclusively rely upon the benefit information provided in this Plan Document and Summary Plan Description only.

9.05 Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered Participant of the Family Unit to use any identification card issued, the Plan Sponsor may give the Employee written notice that coverage of the Employee and all covered family members will be terminated at the end of 31 days from the date written notice is given.

9.06 Statute of Limitations / Forum

Before filing a lawsuit, a Participant must exhaust all available levels of administrative review as described in this Plan, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within 1 year after the date of the notice of Adverse Benefit Determination on the final level of internal or external review, whichever applies. Any action with respect to a fiduciary's alleged breach of any responsibility, duty or obligation hereunder must be brought within 1 year after the date of the alleged breach. Further, any legal action brought against the Plan or Plan Administrator must be brought in federal or state court in the State of Illinois. The Participant, or any Authorized Representative, submits to and accepts the exclusive jurisdiction of such courts for the purpose of such legal action. To the fullest extent permitted by law, the Participant, and any Authorized Representative, irrevocably waive any objection which they may now or in the future have as to venue, as well as any claim that any legal action or proceeding brought in such court has been brought in an inconvenient forum.

ARTICLE X
CLAIM PROCEDURES; PAYMENT OF CLAIMS

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

10.01 Health Claims

All claims and questions regarding health claims should be directed to the Third Party Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them based on its interpretation of the Plan and such interpretation, choice determination, or other exercise of authority by the Plan Administrator will be binding and final upon all affected parties. The responsibility to process claims in accordance with the Plan Document may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

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

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

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

The claims procedures are intended to provide a full and fair review reflecting Federal claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those regulations, those regulations will control. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions. Benefits will be payable to a Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

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

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

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

physician with knowledge of the Participant's medical condition may determine if the claim is a pre-service urgent care claim. If there is no such physician, an individual acting on behalf of the Plan may make the determination applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

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

2. Concurrent Claims. A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:
   a. The Plan Administrator determines that the course of treatment should be reduced or terminated; or
   b. The Participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

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

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

When Health Claims Must Be Filed
Post-service health claims must be filed with the Third Party Administrator within 180 days of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.** A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Third Party Administrator in accordance with the Plan's procedures.

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

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

1. Pre-service Urgent Care Claims:

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

   b. If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.

   c. The Participant will be given a reasonable amount of time to provide the specified information, taking into account the circumstances, but in no event less than 48 hours.

d. The Participant will be notified of a determination of benefits as soon as possible, but not later than the earlier of:
   (1) The Plan's receipt of the specified information; or
   (2) The end of the period afforded the Participant to provide the information.

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

2. Pre-service Non-urgent Care Claims:

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

b. If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Participant will be given 45 days to respond and provide the specified information. The Participant will be notified of a determination of benefits within 15 days from the Plan's receipt of the specified information, or by the date agreed to by the Third Party Administrator and the Participant (if additional information was requested during the extension period).

3. Concurrent Claims:

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

b. Request by Participant Involving Urgent Care. If the Third Party Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Participant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

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

d. Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:
   (1) Notification to Participant : 30 days

(2) Notification of Adverse Benefit Determination on appeal: 30 days

4. Post-service Claims:

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

   b. If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified prior to the expiration of the initial time to respond. The Participant will be given 45 days to respond and provide the specified information. The Participant will be notified of a determination of benefits within 15 days from the Plan's receipt of the specified information, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Third Party Administrator and the Participant.

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

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

7. Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Third Party Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

Notification of an Adverse Benefit Determination

The Third Party Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the Participant. The notice will contain the following information:

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

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

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

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

5. A description of the Plan's internal appeals and external review processes and the time limits applicable to the processes. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action following an Adverse Benefit Determination on final review;

6. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;

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

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

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

10. Information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes (or, if applicable, to request a second level appeal); and

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

10.02 Appeal of Adverse Benefit Determinations

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The Plan provides for 2 levels of appeal following an Adverse Benefit Determination. The Participant has 180 days following an initial Adverse Benefit Determination to file an appeal of that determination, and 60 days following a second Adverse Benefit Determination to file an appeal of that determination. To initiate the appeal process, the Third Party Administrator must receive written request from the Participant, or an Authorized Representative of the Participant, with the proper form for review of an Adverse Benefit Determination.

Full and Fair Review of All Claims

The appeal process of this Plan provides a Participant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

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

2. Participants at least 60 days following receipt of a second Adverse Benefit Determination within which to appeal the determination;

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

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

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

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

7. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

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

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

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

11. Claim appeals will be decided within the timeframe applicable to the type of claim as set forth below.

First Level Appeal

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

HealthSCOPE Benefits
P.O. Box 2860
Little Rock, AR 72203
1-800-397-9598

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

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

1. The name of the Employee/Participant;

2. The Employee/Participant's social security number or alternate identification number;

3. The group name or identification number;

4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal**;

5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

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

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.

2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal at each level.

3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service prior to the termination of the benefit. Coverage under the Plan will continue during the period of review until the appeal is resolved.

4. Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the appeal at each level.

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

Manner and Content of Notification of Adverse Benefit Determination on First Appeal
The Plan Administrator shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

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

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

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

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

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

6. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action following an Adverse Benefit Determination on final review;

7. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;

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

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

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

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

12. Information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes (or, if applicable, to request a second level appeal).

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

Decision on Review
The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal
Upon receipt of notice of the Plan's Adverse Benefit Determination regarding the first appeal, if the Participant does not agree with the determination from the first level of internal review, the Participant has 60 days to file a second appeal of the denial of benefits. The Participant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Participant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Participant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal." The Participant may submit a second appeal in writing, along with any additional supporting information to:

HealthSCOPE Benefits
P.O. Box 2860
Little Rock, AR 72203
1-800-397-9598

The Appeals Committee of the Board of Managers has final responsibility for deciding second level appeals from Plan Participants. The Appeals Committee will review the information initially received and any additional information provided by the Participant and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. No individually identifiable information will be disclosed to the Appeals Committee or other members of the appeals process unless you choose to participate in person at the appeal meeting or you submit a signed authorization form asking the Appeals Committee to consider information that identifies you in connection with your appeal.

Timing of Notification of Benefit Determination on Second Appeal
The Plan shall notify the Participant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than the applicable time period specified in the section entitled "Timing of Notification of Benefit Determination on Review" above. The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

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

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal," as appropriate.

Decision on Second Appeal to be Final
The decision will be final, binding and conclusive, and will be afforded the maximum deference permitted by law. **All Claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

10.03 External Review Process

Scope

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

2. The Federal external review process in accordance with the current Affordable Care Act regulations, applies only to:
   a. Any eligible Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and
   b. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

3. The Federal external review process is not available to claims that have not exhausted the internal appeal process. However, failure by the Plan to follow or adhere to the applicable requirements for internal claims and appeals will result in deemed exhaustion of the internal appeal process and the claimant's right to initiate an external review.

Standard External Review

Standard external review is an external review that is not considered expedited (as described in the Expedited External Review section below).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the 5th month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within 5 business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   a. The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
   b. The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
   c. The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and
   d. The claimant has provided all the information and forms required to process an external review.

   Within 1 business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the U.S. Department of Health and Human Services Health Insurance Assistance Team (HIAT) (toll-free number 888-393-2789). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign to an IRO. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

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

4. Independent Review Organization Determination. Within 45 days after receipt of the external review request, the IRO will provide written notice of it's decision to both the Plan and the claimant.

5. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will provide

coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited External Review

Urgent or Emergency Services

This Plan does not require a Participant to obtain prior approval for pre-service urgent care Claims or Emergency Services before getting treatment; therefore, neither the internal appeals nor the external review procedures will apply to these Claims. In an emergency or urgent care situation, the Participant should follow instructions from his/her health care provider, and file the Claim as a post-service Claim. If the post-service Claim results in an Adverse Benefit Determination, the Participant may file an appeal in accordance with the Plan's provisions for "Appeal of Adverse Benefit Determinations", which are explained above.

Appeals of Claims involving concurrent care will be subject to the Plan's provisions for expedited external review, as explained below.

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
   a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the Plan would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
   b. A first internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the first internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.
   c. A second internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the second internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

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

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign to an IRO. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

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

4. Notice of final external review decision. The Plan's (or Third Party Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, as expeditiously

as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

10.04 Deemed Exhaustion of Internal Claims Procedures and De Minimis

A Participant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Participant may proceed immediately to the External Review Process or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Participant must adhere to them before participating in the External Review Process or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Participant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Participant, and the violation is not reflective of a pattern or practice of non- compliance.

If a Participant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Participant may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within 10 days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Participant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

10.05 Appointment of Authorized Representative

A Participant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Participant to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint such a representative, the Participant must complete a form which can be obtained from the Third Party Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Participant's medical condition to act as the Participant's authorized representative without completion of this form. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

10.06 Physical Examinations

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

10.07 Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

10.08 Assignment of Benefits

Benefits for Covered Expenses under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered along with any Participant cost-sharing amounts. This means that the Plan will reimburse the Provider directly. However, if the Plan pays benefits directly to the Participant, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will only consider valid an Assignment of Benefits as defined under this Plan. Payment of benefits through a valid Assignment of Benefits will be made directly to the

assignee unless a written request not to honor the assignment, signed by the covered Participant and the assignee, has been received before the claim or proof of loss is submitted.

Conditions and Limitations of an Assignment of Benefits:

1. The validity of an Assignment of Benefits by a Participant to a Provider or a Facility is limited by the terms of this Plan Document. An Assignment of Benefits is considered valid on the condition that Provider or Facility accepts the payment received from the Plan as consideration, in full, for Covered Expenses for services, supplies and/or treatment rendered. This amount does not include any cost sharing amounts (i.e. copayments, deductibles, or coinsurance), or charges for non-Covered Expenses; the Provider or Facility may bill the Participant directly for these amounts.

2. An Assignment of Benefits cannot be inferred, implied or transferred. An Assignment of Benefits must be made by the Participant to the Provider or Facility directly through a valid written instrument that is signed and dated by the Participant.

3. Unless specifically prohibited by a Participant, a Provider or Facility with a valid Assignment of Benefits may exhaust, on behalf of the Participant, any administrative remedies available under the terms of the Plan Document, including initiating an internal or external appeal of an adverse benefit determination in accordance with the terms of the Plan Document. Notwithstanding the foregoing, the Participant does not, under any circumstances, have the right to assign to any Provider or Facility (or their representative) through an Assignment of Benefits any right to initiate any cause of action against the Plan that the Participant may be afforded under applicable law. The assignment of any right to initiate suit against the Plan to a Provider or Facility is strictly prohibited.

4. An Assignment of Benefits does not grant the Provider or Facility any rights other than those specifically set forth herein.

5. The Plan Administrator may disregard an Assignment of Benefits at its discretion and continue to treat the Participant as the sole recipient of the benefits available under the terms of the Plan.

6. An Assignment of Benefits by a Participant to a Provider or Facility will not constitute the appointment of an Authorized Representative.

By submitting a claim to the Plan and accepting payment by the Plan, the Provider or Facility is expressly agreeing to the foregoing conditions and limitations of an Assignment of Benefits in addition to the terms of the Plan Document. The Provider or Facility further agrees that the payments received constitute an **'**accord and satisfaction**'** and consideration, in full, for the Covered Expenses for services, supplies and/or treatment rendered. The Provider or Facility agrees that the conditions and limitations of an Assignment of Benefits as set forth herein shall supersede any previous terms and/or agreements. The Provider or Facility agrees to the specific condition that the patient not be balance billed for any amount beyond applicable cost sharing amounts (i.e. copayments, deductibles, or coinsurance), or charges for non-Covered Expenses; the Provider or Facility may bill the Participant directly for these amounts.

10.09 Non U.S. Providers

Medical expenses for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a "Non U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non U.S. Provider;
2. The Participant is responsible for making all payments to Non U.S. Providers, and submitting itemized bills containing diagnosis and service details to the Plan for reimbursement;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;

4. The Non U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
5. Claims for benefits must be submitted to the Plan in English.

10.10 Recovery of Payments

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

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

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

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agrees to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Participant, Provider or other person or entity to enforce the provisions of this section, then that Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

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

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

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

The deduction may be made against any claim for benefits under this Plan by a Participant or by any of his Covered Dependents if such payment is made with respect to the Participant or any person covered or asserting coverage as a Dependent of the Participant. If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Participant for any outstanding amount(s).

10.11 Medicaid Coverage

A Participant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Participant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Participant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan. In all cases, benefits available through a state Medicaid program will be secondary to the benefits of this Plan.

10.12 Patient Advocacy Center and Assistance with Balance Bills

It is the Plan's position that the Provider should not balance bill the Participant for amounts in excess of the Reasonable and Allowable Amount as these Excess Charges are clearly excessive and exorbitant. However, balance billing for such amounts can occur and the Plan has no control over the actions of the Providers or their desire to pursue Participants for such amounts. If you receive a balance bill for an amount in excess of the Patient Responsibility amount reported on your Explanation of Benefits (EOB), please call 1-800-397-9598 toll free for assistance. You will be assigned a customer service representative to resolve your claim with the provider. You should not pay any portion of the balance bill above the amount shown as the Patient Responsibility on your EOB. The customer service representative will keep you informed of the status of the claim and will notify you when your claim is resolved.

Please Note: Customer service representatives provide assistance to Plan Participants with the understanding that (i) they are not acting in a fiduciary capacity under this Plan, (ii) the Participant must make his or her own independent decision with respect to any course of action in connection with any balance-bill, including whether such course of action is appropriate or proper based on the Participant's specific circumstances and objectives, and (iii) customer service does not provide legal or tax advice.

ARTICLE XI
COORDINATION OF BENEFITS

11.01 Benefits Subject to This Provision
This provision shall apply to all benefits provided under any section of this Plan.

11.02 Excess Insurance
If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage. The Plan's benefits will be excess to, whenever possible:

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Worker's compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

11.03 Vehicle Limitation
When medical payments are available (or, under applicable law should be available) under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification. If medical payments would have been available under a vehicle insurance policy if minimum legally required levels of coverage had been in effect, but the minimum level of coverage was not in effect, the Plan will pay excess benefits only, determined as if the minimum legally required level of coverage had been in effect at the applicable time.

11.04 Allowable Expenses
"Allowable expenses" shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the "Application to Benefit Determinations" provision below, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered in the amount that would be payable in accordance with the terms of the Plan shall be deemed to be the benefit. In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Participant does not use an HMO provider, this Plan will not consider as allowable expenses any charge that would have been covered by the HMO had the Participant used the services of an HMO provider.

1. If you are covered under an HMO plan provided by your Participating Employer, no benefits will be payable under this Plan;
2. If you are covered under an HMO plan provided by a plan sponsor other than your Employer and if this Plan is determined to be primary (first to pay) under the Coordination of Benefits (COB) provision of this Plan, then benefits will be payable only if the HMO provider furnishes an itemized statement for services rendered and benefits are assigned to the HMO provider;
3. If you are covered under an HMO plan provided by a plan sponsor other than your Employer and if this Plan is determined to be secondary (second to pay) under the COB provisions of this Plan and if you elect to use the HMO facilities and providers, then only those charges that have not been covered by the HMO plan will be eligible under this Plan. You must submit an itemized copy or receipt for any charges made by the HMO that have not been covered by the HMO plan and a copy of your HMO plan of benefits; or

4. If you are covered under an HMO plan provided by a plan sponsor other than your Employer and if this Plan is determined to be secondary (second to pay) under the COB provision of this Plan and if you elect not to use the HMO facilities or providers, then the only expenses that will be eligible under this Plan are those for which you would have had to pay under the HMO plan if you had used the HMO benefits for which you are eligible. You must submit an itemized copy of your medical expenses and a copy of your HMO plan of benefits.

11.05 "Claim Determination Period"

"Claim Determination Period" shall mean each calendar year.

11.06 Effect on Benefits

11.06A Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the plan's Allowable Expenses. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier. In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

11.06B Order of Benefit Determination

The rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim:

1. A plan without a coordinating provision will always be the primary plan.
2. The plan covering the person directly rather than as a dependent is primary and the other plans are secondary.
3. Active/laid-off or Retirees: The plan which covers a person as an active employee (or as an active employee's dependent) determines its benefits before the Plan which covers a person as a laid-off or retired employee (or as that person's dependent). If the Plan which covers that person has not adopted this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.
4. Dependent children of parents not separated or divorced or unmarried parents living together: The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent and if as a result the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
5. Dependent children of separated or divorced parents or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:
    a. The plan of the parent with custody pays first;
    b. The plan of the spouse of the parent with custody (the step-parent) pays next;
    c. The plan of the parent without custody pays next; and
    d. The plan of the spouse of the non-custodial parent pays last.

    Notwithstanding the above provisions, if there is a court decree that would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan that covers the child as a

dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.

6. If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

11.07 Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any Other Plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

11.08 Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

11.09 Right of Recovery

In accordance with section 10.10, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person’s legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. Please see section 10.10, Recovery of Payments, for more details.

ARTICLE XII
MEDICARE

12.01 For Active Employees And Their Dependents

Federal law requires Employers to offer to active Employees and their covered dependents who are age 65 and over the same health benefits as are available to younger Employees and dependents. If you are such an individual, and you choose to be covered under this Employer group health plan, the Plan's normal Coordination of Benefits provision will not apply; Medicare will be the secondary payor. This Plan will determine what benefits are covered; the remainder of the expenses may then be submitted to Medicare for reimbursement.

If this Plan is the primary payor, your claims should be sent to this Plan first. After this Plan makes its payment, you should then send Medicare a copy of the claim and a copy of this Plan's explanation of benefits (EOB) so that any balance can be considered for payment under Medicare. It will be your responsibility to follow up with Medicare for payment. You should advise all your physicians that this Plan will be the primary payor, and that this Plan should be billed before billing Medicare.

12.02 Participants With End Stage Renal Disease (ESRD)

Medicare has special rules if you are eligible for Medicare because you have end stage renal disease (kidney failure). In most cases, this Plan will be primary for the first 30 months you are eligible for Medicare due to ESRD. After 30 months, Medicare will be the primary payor and this Plan will pay secondary.

This Plan's method of paying secondary to Medicare after the 30-month period will depend on whether you are an active Employee (or a dependent of an active Employee) or a retired Employee (or a dependent of a retired Employee) when your claims are incurred. As long as you remain an active Employee or a dependent of an active Employee, this Plan will pay secondary to Medicare under the rules described in the section above. If you are or become a retired Employee or a dependent of a retired Employee, this Plan will pay secondary to Medicare in the manner described below for retired Employees and their dependents. That is, this Plan will reduce its benefit payment by the amount(s) paid by Medicare.

If this Plan is already paying your claims secondary to Medicare when you become eligible for Medicare due to ESRD, an exception to the 30-month Medicare primary rule applies. This exception applies only if you were already eligible for Medicare due to age or disability and you are a retired Employee or a dependent of a retired Employee. In this case, this Plan will continue to pay your claims secondary to Medicare in the manner described below.

12.03 For Retired Employees And Their Dependents

In the case of Retirees and their covered, Medicare-eligible dependents, this Plan's normal Coordination of Benefits provision will not apply; Medicare will be the primary provider of coverage. If eligible, you must enroll for both Medicare Part A and Part B when you retire. This Plan will calculate the benefit it would have paid if you had no other coverage and then reduce its benefit payment by the amount(s) paid or payable by Medicare. This is true whether or not you are actually enrolled in both Part A and Part B, unless you are not eligible for Medicare. This Plan will never pay more than the maximum amount the Provider is permitted to bill the patient under Medicare rules after Medicare pays its benefit.

Example: Mary is covered under this Plan as a Retiree and is eligible for Medicare. Assume that she has a surgical procedure and incurs $1,000 of expenses. Assume further that Medicare would pay $750 of these expenses and that this Plan would have paid $800 if Mary had not been eligible for other coverage. In this example, this Plan will pay $50.

This Plan's Full Benefit Allowance	$800
Medicare Pays	-$750
After subtracting what Medicare will pay,	
This Plan will pay	$ 50

Because the benefits payable under this Plan are limited, if both the Retiree and spouse or civil union partner are covered by Medicare and they have no other covered dependents, it may be wise to obtain coverage under a Medicare Supplement policy instead of remaining in this Plan.

If Medicare is the primary payor you should send your claims to Medicare first. Make sure you advise your physicians and other providers of service. After you receive payment notification from Medicare, send a copy of the Medicare explanation of benefits and a copy of the bill to this Plan for consideration of any balance not paid by Medicare.

12.04 Medicare and COBRA

For most COBRA beneficiaries (e.g., the working aged or disabled Medicare beneficiaries), Medicare rules state that Medicare will be primary to COBRA continuation coverage and this would apply to this Plan's Continuation of Benefits (COBRA) coverage. For an individual who becomes eligible for Medicare due to ESRD while an active Employee or dependent of an active Employee, COBRA continuation coverage (if elected) is generally primary to Medicare during the 30-month coordination period.

12.05 Coordination of Benefits with TRICARE

The Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.

ARTICLE XIII
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

13.01 Payment Condition

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

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

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

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

13.02 Subrogation

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

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

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

4. If the Participant fails to file a claim or pursue damages against:
   a. The responsible party, its insurer, or any other source on behalf of that party;

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

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

13.03 Right of Reimbursement

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

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

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

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

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

13.04 Excess Insurance

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

   The Plan's benefits shall be excess to:
   a. The responsible party, its insurer, or any other source on behalf of that party;
   b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   c. Any policy of insurance from any insurance company or guarantor of a third party;
   d. Worker's compensation or other liability insurance company; or

e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

13.05 Separation of Funds

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

13.06 Wrongful Death

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

13.07 Obligations

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

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

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

13.08 Offset

If timely repayment is not made, or the Participant and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant in an amount equivalent to any outstanding amounts owed by the Participant to the Plan.

13.09 Minor Status

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

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

13.10 Language Interpretation

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

13.11 Severability

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

Notwithstanding anything contained herein to the contrary, the Plan's right to subrogation and reimbursement may be subject to applicable State subrogation laws.

ARTICLE XIV
MISCELLANEOUS PROVISIONS

14.01 Applicable Law
This is a self-funded benefit plan not subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is intended to comply with the requirements of applicable Federal and/or Illinois State laws.

14.02 Clerical Error/Delay
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

14.03 Conformity With Applicable Laws
It is intended that the Plan will conform to the requirements of any applicable law. This Plan shall be deemed to be amended automatically to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document. Any written notice required under this Plan which is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

14.04 Fraud
The following actions by any Participant, or a Participant's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which the Participant is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Participant of the Plan;
2. Attempting to file a claim for a Participant for services which were not rendered or Drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

14.05 Headings
The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

14.06 Minimum Essential Coverage
The Plan is designed to provide "minimum essential coverage" within the meaning of Code Section 5000A(f) and any accompanying regulations or guidance and provides "minimum value" within the meaning of Code Section 36B(c)(2)(C)(ii) and any accompanying regulations or guidance (e.g., the Plan provides at least 60% actuarial value).

14.07 No Waiver or Estoppel
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

14.08 Plan Contributions
The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employers. The amount of a Participant's contribution (if any) will be determined from time to time by each Participating Employer.

14.09 Right to Receive and Release Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Participant for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

14.10 Right of Recovery
In accordance with section 10.10, Recovery of Payments, whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents.

14.11 Statements
All statements made by the Plan Administrator or by a Plan Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Participant.

Any Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

14.12 Protection Against Creditors
No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. In such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers as permitted under other provisions of this document.

14.13 Unclaimed Self-Insured Plan Funds
In the event a benefits check issued by the Third Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Third Party Administrator shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed.

ARTICLE XV
ELIGIBLE MEDICAL EXPENSES

15.01 Eligible Medical Expenses

Subject to the Plan's provisions, limitations and exclusions, the following are covered major medical benefits:

1. **Acupuncture.** Services by a licensed Doctor of Medicine, Doctor of Osteopathic Medicine or Acupuncturist.

2. **Allergy Services.** Charges related to the treatment of allergies.

3. **Ambulance.** Transportation by professional ambulance, including approved available air and train transportation (excluding chartered air flights), to a local Hospital when determined to be Medically Necessary or transfer to the nearest facility having the capability to treat the condition.

4. **Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care provided.

5. **Anesthesia.** Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff.

6. **Autism Spectrum Disorders.** For Dependents up to age 21, expenses for Medically Necessary diagnosis and treatment of Autism Spectrum Disorders will be covered on the same basis as such services for other medical conditions. The Plan may require the Provider to submit a treatment plan, including diagnosis, proposed treatment by type, frequency, anticipated duration and anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated.

   The following terms have the following meanings:

   a. **Diagnosis of Autism Spectrum Disorders** means one or more tests, evaluations, or assessments to diagnose whether an individual has Autism Spectrum Disorder that is prescribed, performed, or ordered by a Physician licensed to practice medicine in all its branches, or a licensed clinical psychologist with expertise in diagnosing Autism Spectrum Disorders.

   b. **Treatment for Autism Spectrum Disorders** includes the following care prescribed, provided, or ordered for a Dependent diagnosed with an Autism Spectrum Disorder by a Physician licensed to practice medicine in all its branches or by a certified, registered, or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary and ordered by a Physician licensed to practice medicine in all its branches:
      (1) Psychiatric care;
      (2) Psychological care;
      (3) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavioral analysis, that are intended to develop, maintain, and restore the functioning of an individual. Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in behavior;
      (4) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: self care and feeding, pragmatic, receptive and expressive language, cognitive functioning, applied behavior analysis, intervention and modification, motor planning, and sensory processing.

   c. **Medically Necessary.** When used in connection with treatment of Autism Spectrum Disorders, means any care, treatment, intervention, service, or item which is reasonably expected to do any of the following: prevent the onset of an illness, condition, injury, disease, or disability; reduce or ameliorate

the physical, mental, or developmental effects of an illness, condition, injury, disease, or disability; or assist to achieve or maintain maximum functional activity in performing daily activities.

All services for treatment of Autism Spectrum Disorders must be pre-certified as Medically Necessary.

7. **Birth Control/Contraceptives.** Charges for contraceptive procedures and medications, including but not limited to oral contraceptives, patches, injections, diaphragms, intrauterine devices (IUDs), implants, and any related office visit. Some contraceptives may be available under the Prescription Drug or Preventive Care benefits. The Plan covers charges for all FDA-approved contraceptives methods, in accordance with Health Resources and Services Administration (HRSA) guidelines. The Plan does not cover contraceptive supplies or devices available without a Physician's prescription or contraceptives provided over the counter (unless the expense qualifies as Preventive Care).

8. **Birthing Center**. Services of a Birthing Center for Medically Necessary care provided within the scope of its license.

9. **Blood and Plasma.** Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank.

10. **Cardiac Rehabilitation Services.** Charges for Cardiac Rehabilitation Services, as described in the Definitions section of this document.

11. **Cataract Surgery.** Cataract Surgery and initial placement of one pair of eyeglasses, contact lenses, or intraocular lens following Cataract Surgery.

12. **Centers of Excellence.** These centers have the greatest experience in performing transplants or other high cost or highly specialized procedures and the best survival rates. The Plan Administrator shall determine what Centers of Excellence are to be used for the specific procedure.

    Any Participant in need of an organ transplant or other eligible procedure may contact the Third Party Administrator to initiate the pre-certification process resulting in a referral to a Center of Excellence. The Third Party Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all admissions taking place at a Center of Excellence.

    If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

    Additional information about this option, as well as a list of Centers of Excellence, will be given to Participants and updated as requested.

13. **Chemotherapy.** Charges for chemotherapy/radiation;

14. **Chiropractic Care.** Spinal adjustment and manipulation, x-rays for manipulation and adjustment, heat treatment, cold treatment, massage, and other modalities performed by a Physician or other licensed practitioner, as limited in the Schedule of Benefits;

15. **Contraceptives.** The charges for all FDA approved contraceptives methods, in accordance with Health Resources and Services Administration (HRSA) guidelines;

16. **Cosmetic Surgery/Reconstructive Procedures.** Charges for Medically Necessary cosmetic surgery to repair Injury or malformation/birth defect as follows:

a. For the correction of a Congenital Anomaly for a Dependent Child;
b. Any other Medically Necessary Surgery related to an Illness or Injury;
c. Non-cosmetic, Medically Necessary rhinoplasty, blepharoplasty, or brow lift if Incurred after the Participant has been covered under the Plan at least 12 consecutive months or, in the case of rhinoplasty, the procedure is Medically Necessary to correct the results of an accidental Injury;
d. Charges for reconstructive breast Surgery following a mastectomy will be eligible as follows:
    (1) Reconstruction of the breast on which the mastectomy has been performed;
    (2) Surgery and reconstruction of the other breast to produce symmetrical appearance; and
    (3) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas;
    (4) Prosthetic devices include breast prostheses and bras.
    (5) Coverage for post-mastectomy care including:
        1. Inpatient Hospital care following a mastectomy, for a length of stay as determined by the attending Physician to be Medically Necessary.
        2. Post-discharge Physician office visit or in-home nurse visit within 48 hours of discharge.

    The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the Participant.

17. **Dental Care.** Expenses for any care or treatment of teeth, gums or alveolar process will not be considered eligible unless such expenses are for:

    a. Reduction of fractures of the jaw or facial bones;
    b. Surgical correction of harelip, cleft palate or protruding mandible;
    c. Removal of stones from salivary ducts;
    d. Bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues;
    e. Freeing of muscle attachments;
    f. Hospital outpatient or inpatient charges in connection with oral surgery, extractions or other non-cosmetic dental procedures, but only if treatment in a Hospital setting is Medically Necessary for the patient's condition (this includes only Hospital facility charges and does not include charges of a Dentist or Oral Surgeon for non-covered dental procedures, anesthesia or other charges);
    g. Emergency medical services related to an Injury to sound, natural teeth.

18. **Diabetic Education**. The following diabetic education and self-management programs: diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with diabetes.

19. **Diabetic Supplies**. All Physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes that are not covered under the Prescription Drug Card Program or under Durable Medical Equipment.

20. **Diagnostic Tests; Examinations.** Charges for x-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy, Cologuard screening and other diagnostic tests and procedures. Dental x-rays are not eligible expenses, except when performed relating to Emergency Medical Services for Injury to sound, natural teeth or other covered dental surgery as specified under "Dental Care."

    The Plan will cover Cologuard screening once every 3 years for Participants who meet all of the following criteria:
    a. Age 50 to 85 years;

b. Asymptomatic (exhibit no signs or symptoms of colorectal disease, including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test); and
c. At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

21. **Durable Medical Equipment (DME).** Charges for rental, up to purchase price, of Durable Medical Equipment (DME), including glucose home monitors for insulin-Dependent diabetics. The equipment will be provided on a rental basis, but may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will rental cost of DME exceed the purchase price of the item (oxygen equipment is not limited to the purchase price). The Plan covers routine maintenance and repair due to Participant's growth and development if DME was initially provided 3 or more years prior. Diabetic pump supplies are covered under the Plan.

    Please note the pre-certification requirements and penalties for Durable Medical Equipment.

22. **Elective Abortion.** Elective induced abortions for an Employee, Spouse, or Civil Union Partner.

23. **Foot Care**. Treatment for the following foot conditions: (a) toenails when at least part of the nail root is removed; (b) any Medically Necessary Surgery required for a foot condition. In addition, orthopedic shoes when an integral part of a leg brace will also be covered, as well as the initial purchase, fitting and repair of custom-fitted foot orthotics when determined to be Medically Necessary by the attending Physician are covered by the Plan. Routine foot care is covered for the treatment of diabetes.

24. **Genetic Testing.** Charges for diagnostic testing of Genetic Information and counseling when Medically Necessary, including but not limited to:

    a. Diagnostic testing where the patient is showing symptoms of disease and those symptoms correspond to a medically recognized genetic disorder;
    b. Diagnostic testing when testing is performed on the DNA of an invading virus or bacterium for the purpose of identifying and treating a specific contagious disease;
    c. Predictive testing if the Participant's family history establishes the patient is at risk for a genetic disease, but only if there are accepted treatment alternatives for that condition;
    d. Prenatal testing when the pregnancy is categorized as high-risk, including cases where the mother or father has a family history that establishes that parent is at risk for having a hereditary genetic disorder.

25. **Hemodialysis/Peritoneal Dialysis.** Treatment of a kidney disorder by hemodialysis or peritoneal dialysis as an Inpatient in a Hospital or other facility or for expenses in an outpatient facility or in the Participant's home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Participant's home as shown under the Durable Medical Equipment benefit. Dialysis treatment includes injectable and intravenous medication administered directly before, during or after a dialysis procedure.

    Please note the pre-certification requirements and penalties for Dialysis.

26. **Home Health Care.** Services provided by a Home Health Care Agency to a Participant in the home. The following are considered eligible home health care services:

    a. Part-time or intermittent home nursing care;

b. Part-time or intermittent services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.);
c. Visits provided by a medical social worker (MSW);
d. Physical, occupational or speech therapy if provided by the Home Health Care Agency;
e. Medical supplies, drugs and medications prescribed by a Physician;
f. Laboratory services; and
g. Nutritional counseling by a licensed dietician.

For the purpose of determining the benefits for home health care available to a Participant, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each 4 hours of home health aide services shall be considered as one home health care visit.

In no event will the services of a Close Relative, custodial care, private duty nursing, transportation services, housekeeping services and meals, etc., be considered an eligible expense.

Please note the pre-certification requirements and penalties for Home Health Care.

27. **Home Infusion Therapy**. Services, supplies and equipment necessary for home infusion therapy.

28. **Hospice Care.** Charges relating to Hospice Care. The hospice treatment plan must certify the Participant is terminally ill with a life expectancy of 6 months or less. Covered Hospice expenses are limited to:

    a. Room and Board for Confinement in a Hospice;
    b. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness;
    c. Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
    d. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.);
    e. Home health aide services;
    f. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide;
    g. Medical social services by licensed or trained social workers, Psychologists or counselors;
    h. Nutrition services provided by a licensed dietitian;
    i. Respite care, if provided on an intermittent, non-routine, occasional basis over a period of no longer than 10 consecutive days.

    Hospice Care ceases if the terminal Illness enters remission. Please note the pre-certification requirements and penalties for Hospice Care.

29. **Hospital Services or Long-Term Acute Care Facility/Hospital.** Charges made by a Facility/Hospital for:

    a. Inpatient Treatment
        (1) Daily Semi-Private Room and Board charges;
        (2) Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges;
        (3) General nursing services; and
        (4) Medically Necessary services and supplies furnished by the Hospital, other than Room and Board.

    b. Outpatient Treatment
        (1) Emergency room;
        (2) Treatment for chronic conditions;
        (3) Physical Therapy treatments;
        (4) Hemodialysis; and

(5) X-ray, laboratory and linear therapy.

Please note the pre-certification requirements and penalties for Hospital Services;

30. **Infertility Treatment.** Diagnostic procedures, surgical procedures and drug therapies for the treatment of infertility will be considered as any other covered expenses, provided that the Participant has been diagnosed by a Physician as requiring treatment for Infertility.

    Infertility is defined as the inability to conceive after 12 months of unprotected sexual intercourse or the inability to sustain a successful pregnancy by a woman of normal childbearing age.

    In addition, the Assisted Reproduction Techniques listed below will be considered as Covered Expenses up to the Lifetime Maximum benefit stated on the Medical Schedule of Benefits, provided that the following conditions are satisfied:

    a. The Participant has attempted, but has been unable to attain or sustain, a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments;
    b. The treatment conforms to the guidelines of the American College of Obstetrics and Gynecology or the standards of the American Society of Reproductive Medicine.

    Subject to these conditions, the following Assisted Reproduction Techniques are the only services subject to the Lifetime Maximum benefit:

    a. Medical costs of oocyte or invasive sperm retrieval;
    b. In vitro fertilization;
    c. Uterine embryo lavage;
    d. Embryo transfer;
    e. Artificial insemination;
    f. Gamete intrafallopian tube transfer;
    g. Zygote intrafallopian tube transfer;
    h. Low tubal ovum transfer; and
    i. Other medically recognized techniques that are not considered Experimental or Investigational at the time the treatment is provided.

    The following are <u>not covered</u> by the Plan:

    a. Costs associated with cryopreservation and storage of egg, sperm or embryo;
    b. Experimental treatments;
    c. Fertility treatment for a person who has undergone a voluntary sterilization procedure; and
    d. Fertility treatment for a person who is beyond normal child-bearing age.

31. **Lenses.** Initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgery to the eye for aphakic patients. Soft lenses or sclera shells intended for use as corneal bandages.

32. **Mastectomy**. The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy. As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

    a. Reconstruction of the breast on which the Mastectomy has been performed;
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient. This coverage will be subject to the same annual Deductible and coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with you and your attending Physician.

33. **Maternity**. Expenses Incurred by an Employee, Dependent Spouse or a civil union partner for:

    a. Pregnancy;
    b. Preventive prenatal and breastfeeding support as identified under the preventive services section below;
    c. Services provided by a Birthing Center;
    d. One amniocentesis test per Pregnancy;
    e. Up to 2 ultrasounds per Pregnancy (more than 2 only when it is determined to be Medically Necessary);
    f. Elective induced abortions.

    Maternity expenses are considered as any other illness under the Plan for covered Employees and covered spouses or civil union partners of Employees. Charges include preventive prenatal and breastfeeding support as identified under the preventive services section. The charges incurred by a newborn while confined at the time of birth will be considered under the newborn's own coverage as long as the newborn has been enrolled for coverage under this Plan. However, no deductible will apply to the inpatient hospital facility charges for the baby. **No benefits are payable on behalf of the newborn if the newborn is not enrolled in the Plan within the required period.** See the Eligibility section of this booklet.

    There are no benefits available for charges related to the pregnancy of a Dependent child or complications of pregnancy of a Dependent child except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan. Please refer to the Women's Preventive Services section below.

    Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Participant or provider is not required to pre-certify the maternity admission, unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

    If a mother or newborn remains hospitalized beyond the time frames specified above, the confinement must be pre-certified or a penalty may be applied.

34. **Medical Supplies.** Dressings, casts, splints, trusses, braces, crutches, orthotics and custom made orthopedic shoes and other Medically Necessary medical supplies, when ordered by a Physician, including syringes for diabetic and allergy diagnosis, and lancets and chemstrips for diabetics.

35. **Mental Disorders, Alcohol and/or Substance Use Disorders.** Treatment of Mental Disorders of any type, regardless of cause or origin, including but not limited to ICD 10 codes F01 – F99, may be provided by an M.D. or Ph.D. Clinical Psychologist, or by a master's level counselor (M.A.) or Master of Social Work (M.S.W.), provided they are licensed in the political jurisdiction where practicing, acting within the scope of their licenses and performing services ordered by an M.D., D.O. or a Ph.D. clinical psychologist.

    Benefits include services for the following:

a. inpatient and outpatient services, limited to the Lifetime Maximum day limits for inpatient services and the Calendar Year maximum visit limits for outpatient services stated in the Medical Schedule of Benefits;
b. partial confinements or day programs provided the Physician has recommended such care as an alternative or in lieu of inpatient confinement (2 partial day confinements will be treated as one inpatient day for purposes of the lifetime inpatient day limit);
c. both in and outpatient Physicians visits are limited to one per day;
d. services must be rendered by a provider covered under the Plan.

All inpatient services, including treatment in a Rehabilitation Facility, must be pre-certified.

Important Note: Group health plans sponsored by State and local governmental employers such as public school districts must generally comply with Federal law requirements in Title XXVII of the Public Health Service Act. However, such employers are permitted to elect to exempt a plan from certain requirements for any plan that is "self-funded" rather than provided through a health insurance policy. The Plan Sponsor has elected to exempt this Plan from some requirements of the Mental Health Parity and Addiction Equity Act which generally prevents plans from having more restrictive benefits for mental health and substance abuse disorders than for other covered medical and surgical conditions. This exemption will continue in effect through August 31, 2019, and may be renewed for subsequent Plan Years.

The following services will be considered as any other illness and are not limited to the Mental/Nervous, Alcohol and/or Substance Abuse provisions:

a. prescription drugs (considered under the prescription drug benefit);
b. laboratory tests for prescribed drug levels when performed by an independent lab;
c. surgical procedures and related expenses;
d. electroshock therapy and related anesthesia provided by an independent anesthesiologist;
e. charges readily identified as relating to the treatment of an acute medical condition caused by alcoholism, chemical addiction or abuse or drug addiction or abuse;
f. charges for diagnosis and treatment of Autism Spectrum Disorders.

36. **Morbid Obesity**. Surgical procedures for treatment of obesity (including gastric stapling, gastric pouching, surgical resection and any other surgical treatment of obesity) will be considered as eligible medical expenses only if all of the following requirements are satisfied and subject to the limitations stated below.

Requirements:

a. the Participant meets the requirements for morbid obesity stated in the Definitions;
b. the Participant has another serious medical condition such as degenerative joint disease, pulmonary and circulatory insufficiency, diabetes or heart disease which is aggravated or caused by the excess weight; and
c. the patient or Physician provides evidence that conventional weight reduction methods have failed.

37. **Newborn Care.** Hospital and Physician nursery care for Newborns who are properly enrolled in the Plan, as set forth below. No Deductible will apply to the Inpatient Hospital/Facility charges for the baby. Benefits will be provided under the baby's coverage;

a. Hospital routine care for a Newborn during the child's initial Hospital Confinement at birth; and
b. The following Physician services for well-baby care during the Newborn's initial Hospital Confinement at birth:
    (1) The initial Newborn examination and a second examination performed prior to discharge from the Hospital and routine pediatric care while confined; and
    (2) Circumcision.

NOTE: The Plan will cover Hospital and Physician nursery care for an ill Newborn as any other medical condition, provided the Newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage.

There are no benefits available for charges related to the pregnancy of a Dependent child or complication of pregnancy of a Dependent child except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan. Refer to Women's Preventive Services below.

38. **Nursing Services.** Services of a Registered Nurse or Licensed Practical Nurse.

39. **Nutritional Counseling.** Charges for Nutritional Counseling where a letter of Medical Necessity has been provided by the prescribing Physician. Coverage shall be limited to one nutritional counseling session per primary medical condition per lifetime, not to exceed 10 classes per session. Conditions for which nutritional evaluation and counseling may be considered Medically Necessary include, but are not limited to, the following:

    a. Anorexia Nervosa/Bulimia;
    b. Celiac Disease;
    c. Cardiovascular disease;
    d. Crohn's Disease;
    e. Diabetes Mellitus;
    f. Hyperlipidemia;
    g. Hypertension;
    h. Liver Disease;
    i. Malabsorption Syndrome;
    j. Metabolic Syndrome;
    k. Multiple or severe food allergies;
    l. Nutritional deficiencies;
    m. Obesity;
    n. Renal failure; and
    o. Ulcerative Colitis.

    Specifically excluded is Nutritional Counseling solely for the management of the following conditions:

    a. Attention Deficit/Hyperactive Disorder;
    b. Chronic Fatigue Syndrome;
    c. Idiopathic Environmental Intolerance (casual connection between environmental chemicals, foods, and/or other drugs).

40. **Nutritional Supplements:** Physician-prescribed nutritional supplements or other enteral supplementation necessary to sustain life, including rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation. Special dietary treatment for phenylketonuria (PKU) when prescribed by a Physician.

    Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

41. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, for therapeutic treatment of a covered Illness or Injury to improve a body function. Expenses for Maintenance Therapy or therapy primarily for recreational or social interaction will not be considered eligible.

    Please note the pre-certification requirements and penalties for occupational therapy.

42. **Off-Label Drug Use**. Expenses related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage only when all of the following criteria have been satisfied:

    a. The named drug is not specifically excluded under the General Exclusions and Limitations section of the Plan;
    b. The named drug has been approved by the FDA;
    c. The Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and
    d. If the drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information or NCCN Drugs and Biologics Compendium recognize it as an appropriate treatment for that form of cancer.

43. **Outpatient Pre-Admission Testing**. Outpatient pre-admission testing performed within 72 hours of a scheduled Inpatient hospitalization or Surgery.

44. **Pain Medication and Pain Therapy:** Charges for pain medication and pain therapy related to the treatment of breast cancer, or otherwise when medically appropriate;

45. **Pathology Services.** Charges for Pathology Services;

46. **Physical Therapy.** Treatment or services rendered by a physical therapist, under direct supervision of a Physician, for therapeutic treatment of a covered Illness or Injury which is subject to significant improvement through short term therapy. Maintenance Therapy generally will not be considered eligible.

    Please note the pre-certification requirements and penalties for physical therapy.

47. **Physician Services.** Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations.

48. **Podiatry.** Charges for Podiatry services; capsular or bone surgery for bunions; procedures or injections related to bone, nerve, muscle, or tendon; and cutting or removal of corns, calluses, or toenails. Treatment for the following foot conditions is also covered: (a) toenails when at least part of the nail root is removed; (b) any Medically Necessary surgical procedure required for a foot condition. Routine foot care is covered for treatment of diabetes.

49. **Pre-Admission Testing.** If a Participant is to be admitted to a Hospital for non-Emergency Surgery or treatment, one set of laboratory tests and x-ray examinations performed on an outpatient basis within 7 days prior to such Hospital admission will be paid, with no Deductible, at 100% of the Reasonable and Allowable fees, provided that the following conditions are met:

    a. The tests are related to the performance of the scheduled Surgery or treatment;
    b. The tests have been ordered by a Physician after a condition requiring Surgery or treatment has been diagnosed and Hospital admission has been requested by the Physician and confirmed by the Hospital;
    c. The Participant is subsequently admitted to the Hospital, or confinement is cancelled or postponed because a Hospital bed is unavailable or if, after the tests are reviewed, the Physician determines that the confinement is unnecessary; and
    d. The tests are performed in the Hospital where the confinement will take place and accepted in lieu of duplicate tests rendered during confinement.

50. **Prescription Drugs**. Prescription Drugs that are not covered under the Prescription Drug Card Benefit. Prescription Drugs must be FDA approved and determined to be Medically Necessary and appropriate treatment. Please note the pre-certification requirements and penalties for certain specialty infusion drugs.

51. **Preventive Care.** Preventive Care services mandated through the Affordable Care Act include services such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

    See http://www.uspreventiveservicestaskforce.org or https://www.healthcare.gov/preventive-care-benefits/ for more details.

    Preventive and Wellness Services for Adults and Children. In compliance with the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

    Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

    With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

    A description of Preventive and Wellness Services can be found at: https://www.healthcare.gov/preventive-care-benefits/.

    Women's Preventive Services. With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration not otherwise addressed by the recommendations of the United States Preventive Service Task Force, which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

    a. Well-woman visits;
    b. Gestational diabetes screening;
    c. HPV DNA testing;
    d. Sexually transmitted infection counseling;
    e. HIV screening and counseling;
    f. FDA-approved contraception methods and contraceptive counseling;
    g. Breastfeeding support, supplies and counseling; and
    h. Domestic violence screening and counseling.

    A description of Women's Preventive Services can be found at:
    http://www.hrsa.gov/womensguidelines/ or at https://www.healthcare.gov/preventive-care-benefits/.

    Breastfeeding equipment will be covered, subject to the following:

    a. Rental of a Hospital grade electric pump while the baby is Hospital confined; and
    b. Purchase of a standard (non-Hospital grade) electric breast pump or manual breast pump if requested during the duration of breastfeeding, provided the Participant has not received either a standard electric breast pump or a manual breast pump within the last 3 Calendar Years and provided the Participant remained continuously enrolled in the Plan.

c. For women using a breast pump from a prior pregnancy, one new set of breast pump supplies will be covered at 100% with each subsequent pregnancy for initiation or continuation of breastfeeding.

52. **Private Duty Nursing.** Private duty nursing (outpatient only). Expenses for private duty nursing will not be considered eligible, except those services which are considered eligible under the Hospice Care benefits;

53. **Prosthetic Devices.** Artificial limbs, eyes or other prosthetic devices when necessary due to an Illness or Injury. This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan, but no more than every 5 years for normal wear. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered. Please note the pre-certification requirements and penalties for prosthetic devices;

54. **Pulmonary Rehabilitation.** Charges for Pulmonary Rehabilitation;

55. **Radiation Therapy.** Charges for radiation therapy and treatment;

56. **Rehabilitation Facility.** Inpatient care in a Rehabilitation Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Skilled Nursing Facility confinement; and (c) is not for Custodial Care;

    See the Skilled Nursing Facility benefit for services and supplies provided for confinements in a Skilled Nursing Facility.

57. **Respiration Therapy.** Respiration therapy services, when rendered in accordance with a Physician's written treatment plan;

58. **Rhinoplasty.** Expenses related to rhinoplasty, Blepharoplasty or brow lift performed for non-cosmetic reasons will not be considered eligible, unless such charges are incurred after the individual has been covered under the Plan at least 12 consecutive months or, in the case of rhinoplasty, the procedure is necessary to correct the results of an accidental injury. Any such surgical procedures performed for cosmetic reasons will not be considered eligible;

59. **Routine Patient Care in an Approved Clinical Trial.** Charges for any Medically Necessary routine patient care provided to a Participant participating in an approved phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, provided:

    a. The clinical trial is approved by:
        (1) The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
        (2) The National Institute of Health;
        (3) The U.S. Food and Drug Administration;
        (4) The U.S. Department of Defense;
        (5) The U.S. Department of Veterans Affairs; or
        (6) An Institutional review board of an Institution in the State of Illinois that has an agreement with the Office for Human Research Protections in the U.S. Department of Health and Human Services;

    b. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable

Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial; and

c. The provider submits a detailed treatment plan designating all proposed treatment as routine patient care or investigational and/or research related care.

Routine patient care does not include and coverage will not be provided for:

a. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, or any drug or device that is the subject of the Approved Clinical Trial;
b. The cost of a service that is not a covered health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial;
c. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis;
d. A cost associated with managing an Approved Clinical Trial;
e. The cost of a health care service that is specifically excluded by the Plan; or
f. Services that are part of the subject matter of the Approved Clinical Trial or any associated research costs and that are customarily paid for by the research Institution conducting the Approved Clinical Trial.

60. **Second Surgical Opinions.** Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Participant. Benefits for the second opinion will be payable only if the opinion is given by a specialist who: (a) is certified in the field related to the proposed Surgery; and (b) is not affiliated in any way with the Physician recommending the Surgery. If the second opinion conflicts with the first opinion, the Participant may obtain a third opinion, although this is not required.

61. **Skilled Nursing Facility.** Charges made by a Skilled Nursing Facility or a Convalescent Care Facility in connection with convalescence from an Illness or Injury for which the Participant is confined. Custodial care is not covered.

Please note the pre-certification requirements and penalties for Skilled Nursing Facility.

62. **Speech Therapy.** Speech therapy by a Physician or qualified speech therapist, when needed due to a Sickness or Injury (other than a functional nervous disorder) or due to surgery performed as the result of a Sickness or Injury, excluding Speech Therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders;

Please note the pre-certification requirements and penalties for Speech Therapy.

63. **Sterilization**. All FDA approved charges related to sterilization procedures in addition to and to the extent required by the Affordable Care Act (ACA). Reversal of sterilization is not covered.

64. **Surgery.** Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:

a. Multiple procedures adding significant time or complexity will be allowed at:
    (1) 100% of the full Reasonable and Allowable fee value for the first or major procedure;
    (2) 50% of the Reasonable and Allowable fee value for the secondary and subsequent procedures;
b. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at 100% of Reasonable and Allowable fee value for the major procedure, and 50% of the Reasonable and Allowable fee value for the secondary or lesser procedure;
c. Charges made for services rendered by an assistant surgeon will be allowed at 25% of the Reasonable and Allowable fee value for the type of surgery performed;

d. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session.

65. **Taxes and Surcharges.** Taxes and/or surcharges applied to a covered expense are considered Covered Expenses when the tax or surcharge is mandated by state or federal law.

66. **Temporomandibular Joint Disorder (TMJ).** Surgical and non-surgical charges for the diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofascial pain dysfunction or orthognathic treatment.

67. **Total Parenteral Nutrition (TPN).** Charges for Total Parenteral Nutrition for pre- or post-surgical patients, or when determined to be Medically Necessary in order to safeguard the Participant's life. A statement of Medical Necessity from the attending Physician must be submitted prior to receiving services in cases that are other than pre- or post-surgical related.

68. **Transplants.** Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:

    a. Bone marrow;
    b. Heart;
    c. Lung;
    d. Heart and lung;
    e. Liver;
    f. Pancreas;
    g. Kidney;
    h. Cornea; and
    i. Other transplant procedures approved under Medicare guidelines.

    Covered expenses include:

    a. Organ or tissue procurement from a live donor consisting of removing, preserving, and transporting the donated part;
    b. Services and supplies furnished by a Provider; and
    c. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

    Surgical, storage and transportation costs, including donor medical expenses, directly related to the procurement of an organ or tissue used in a transplant described herein will be covered for each such procedure completed. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue.

    Centers of Excellence are available and should be used for all transplant services. All transplants must be pre-certified. The Third Party Administrator or care managers will assist you in identifying the Centers of Excellence approved for the procedure you require.

    Travel and lodging expenses are covered by the Plan up to $10,000 per transplant. This is a combined maximum for the patient, companion and donor. Lodging expenses are also subject to a limit of $50 per night per person, up to a maximum of $100 per night. One companion is permitted per adult and 2 parents or guardians are permitted per child.

    If the donor and the recipient are both Plan Participants, the donor's coverage will pay the donor's charges. The Plan will not cover the donor's charges if the donor is a Participant and the recipient is not a Participant.

ARTICLE XVI
GENERAL EXCLUSIONS AND LIMITATIONS

16.01 Exclusions and Limitations

No payment will be eligible under any portion of this Plan for expenses Incurred by a Participant for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Participant or from future benefits and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

1. **Adoption.** Expenses related to adoption will not be considered eligible.

2. **Artificial Insemination.** Expenses for artificial insemination, in-vitro fertilization or embryo or fetal implants, or other assisted reproduction techniques will not be considered eligible, except as specified under Infertility Treatment under Eligible Medical Expenses.

3. **Cardiac Rehabilitation.** Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

4. **Claims More than 6 Months Old.** Expenses for services or supplies that were provided more than 6 months prior to the date the charges are submitted to the Plan for payment will not be considered eligible.

5. **Close Relative.** Expenses for services, care or supplies provided by a person who normally resides in the Participant's home or by a Close Relative will not be considered eligible.

6. **Complications from Non-Covered Treatment.** Expenses for care, services or treatment required as a result of complications from a treatment or procedure not covered under the Plan will not be considered eligible.

7. **Convenience Items.** Expenses for personal hygiene and convenience items will not be considered eligible.

8. **Cosmetic Procedures.** Expenses for Cosmetic and reconstructive procedures will not be considered eligible, except as specified under Eligible Medical Expenses.

9. **Counseling.** Expenses for religious, marital, family, bereavement or relationship counseling will not be considered eligible, except as specified under Eligible Medical Expenses.

10. **Custodial Care.** Expenses for Custodial Care will not be considered eligible, except as specified under the Hospice Care benefits. For the purpose of this limitation, expenses Incurred for care comprised of accommodations including room and board and other institutional services, nursing services provided to a Participant because of age or other mental or physical conditions, or services primarily to assist the Participant in the activities of daily living, shall be deemed custodial care. The fact that the Participant is concurrently receiving medical services that are merely maintenance care and cannot reasonably be expected to contribute substantially to the improvement of a medical condition shall not preclude the application of this limitation.

11. **Dental Care.** Expenses Incurred in connection with dental care, treatment, x-rays, general anesthesia or Hospital expenses will not be considered eligible, except as specified under Eligible Medical Expenses. Removal of impacted teeth will not be considered eligible.

12. **Error.** Expenses required to treat injuries that are sustained or an illness that is contracted, including infections and complications, while the Participant was under, and due to, the care of a Provider wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

13. **Excess.** Expenses that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Reasonable and Allowable amount.

14. **Exercise Programs.** Exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

15. **Experimental and/or Investigational.** Expenses for treatment, procedures, devices, drugs or medicines, except covered charges for Off-Label Drug Use or routine patient care provided in connection with an approved clinical trial, which are determined to be Experimental and/or Investigational will not be considered eligible.

16. **Foot Care.** Expenses Incurred for the treatment of corns, calluses or toenails will not be considered eligible unless charges are for the removal of nail roots or in conjunction with the treatment of a metabolic or peripheral-vascular disease and as specified under Eligible Medical Expenses.

17. **Foot Orthotics.** Expenses for foot only orthotics, orthopedic shoes (except those that are an integral part of a leg brace), arch supports or for the exam, prescription or fitting thereof will not be considered eligible, except as specified under Eligible Medical Expenses.

18. **Gambling Addiction.** Expenses for services related to gambling addiction will not be considered eligible.

19. **Governmental Agency.** Expenses for services and supplies which are provided by any governmental agency for which the Participant is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Participant eligible under TRICARE (the government sponsored program for military dependents). (For treatment in Veteran Administration facilities, the law generally requires the Plan to provide benefits for a covered individual who does not have a service-connected disability).

20. **Hair Loss.** Expenses for hair loss or hair transplants will not be considered eligible, except as specified under Eligible Medical Expenses.

21. **Hearing Exams/Aids.** Expenses for routine hearing examinations, hearing aids (including the fitting thereof) and supplies will not be considered eligible, except routine preventive care required for children under the Affordable Care Act.

22. **Homeopathic Treatment.** Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.

23. **Hypnotherapy.** Expenses for hypnotherapy will not be considered eligible.

24. **Illegal Occupation/Felony.** Expenses for or in connection with an Injury or Illness arising out of an illegal occupation or commission of a felony will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.

25. **Maintenance Therapy.** Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.

26. **Massage Therapy.** Expenses for massage therapy will not be considered eligible, except when part of an overall patient treatment plan and the services are provided by an eligible provider.

27. **Maternity.** Maternity expenses Incurred by a Dependent other than an Employee's Spouse or Civil Union Partner will not be considered eligible except as otherwise covered as a preventive service as specified under the Eligible Medical Expenses section of the Plan.

28. **Medical Expenses.** Expenses for any services, supplies, charges or expenses which are not included under Eligible Medical Expenses will not be considered eligible.

29. **Medically Necessary.** Expenses which are determined not to be Medically Necessary will not be considered eligible.

30. **Missed Appointments.** Expenses for completion of claim forms, missed appointments or telephone consultations will not be considered eligible. This exclusion does not apply to telephone consultations provided as part of the Teladoc program.

31. **Morbid Obesity.** Expenses for non-surgical treatment of Morbid Obesity will not be considered eligible.

32. **Negligence.** Expenses for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

33. **No Legal Obligation.** Expenses for services provided for which the Participant has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires this Plan to be primary.

34. **Non-Covered Procedures.** Expenses for services related to a non-covered Surgery or procedure will not be considered eligible regardless of when the Surgery or procedure was performed.

35. **Not Acceptable.** Expenses for services that are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration.

36. **Not Performed Under Direction of a Physician.** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

37. **Not Recommended by a Physician.** Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.

38. **Nutritional Supplements.** Expenses for nutritional supplements or other enteral supplementation will not be considered eligible, except as specified under Eligible Medical Expenses. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

39. **Obesity.** Surgical and non-surgical care and treatment of obesity including weight loss or dietary control, whether or not it is in any case a part of a treatment plan for another Illness, will not be considered eligible, except as specified under Eligible Medical Expenses or the Prescription Drug Benefit or as otherwise covered as a preventive service under the Plan.

40. **Occupational Therapy.** Expenses for occupational therapy primarily for recreational or social interaction will not be considered eligible.

41. **Operated by the Government.** Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Participant is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Participant for a non-service related Illness or Injury.

42. **Outside the United States (U.S.).** Expenses for services or supplies if the Participant leaves the U.S. or the U.S. Territories for the express purpose of receiving medical treatment will not be considered eligible, unless the charges are Incurred while the Participant is traveling on business or pleasure.

43. **Over-the-Counter (OTC) Medication.** Expenses for any over-the-counter medication obtained without a prescription will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan or as described in the Prescription Drug Card Program section.

44. **Plan Maximums.** Charges in excess of Plan benefit maximums will not be considered eligible.

45. **Prior to or After Effective Date.** Expenses which are Incurred prior to the effective date of your coverage or after the effective date of termination of your coverage under the Plan will not be considered eligible.

46. **Private Duty Nursing.** Expenses for private duty nursing will not be considered eligible, except those nursing services which are considered eligible under the Hospice Care benefits.

47. **Prohibited by Law.** Expenses to the extent that payment under this Plan is prohibited by law.

48. **Recreational and Educational Therapy.** Expenses for recreational and educational services; learning disabilities; behavior modification services; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies; will not be considered eligible. Diabetic education is considered eligible as specified under Eligible Medical Expenses. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.

49. **Refractive Errors.** Expenses for radial keratotomy, Lasik Surgery or any Surgical Procedure to correct refractive errors of the eye will not be considered eligible.

50. **Required by Law.** In any case where an individual is required by law to maintain insurance coverage (or to maintain any other security or reserve amount in lieu of insurance coverage), expenses of a Participant that would be paid by such insurance coverage are not eligible expenses, regardless of whether the individual is in fact covered under such coverage. For purposes of any required automobile, motorcycle or other vehicle coverage, otherwise eligible expenses below the minimum required coverage or the actual coverage elected, whichever is higher, will be excluded from coverage under this Plan.

51. **Rhinoplasty.** Expenses related to rhinoplasty, Blepharoplasty or brow lift performed for non-cosmetic reasons will not be considered eligible, unless such charges are incurred after the individual has been covered under the Plan at least 12 consecutive months or, in the case of rhinoplasty, the procedure is necessary to correct the results of an accidental injury. Any such surgical procedures performed for cosmetic reasons will not be considered eligible.

52. **Riot/Revolt.** Expenses resulting from a Participant's participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

53. **Routine Care.** Expenses for routine care, including x-ray, laboratory tests, vaccinations and immunizations will not be considered eligible, except as specified under Eligible Medical Expenses.

54. **Self-Inflicted Injury.** Expenses for Injury or Illness arising out of attempted suicide or an intentional self-inflicted Injury will not be considered eligible. This exclusion will not apply if self-inflicted Injuries result from a medical condition (physical or mental) or act of domestic violence and the benefits for such Injuries are normally covered under the Plan.

55. **Services to Lessen Patient's Disability.** Expenses related to services that cannot reasonably be expected to lessen the patient's disability and to enable the patient to live outside of an institution will not be considered eligible, except as specifically covered under Hospice Care.

56. **Sex Transformation.** Expenses in connection with sex transformation (gender reassignment) will not be considered eligible.

57. **Sleep Disorder.** Expenses for treatment, services and supplies for sleep disorders unless Medically Necessary will not be considered eligible.

58. **Sterilization Reversal.** Expenses for the reversal of elective sterilization will not be considered eligible.

59. **Subrogation, Reimbursement, and/or Third Party Responsibility**. Expenses that are not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

60. **Surrogate.** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan, including but not limited to pre-pregnancy, conception, pre-natal, childbirth and post-natal expenses, will not be considered eligible.

61. **Travel.** Expenses for travel will not be considered eligible, except as specified under Eligible Medical Expenses.

62. **Vaccinations, Inoculations and Immunizations.** Expenses for vaccinations, inoculations and immunizations will not be considered eligible, unless they are recommended preventive services. See the Preventive Care section under Eligible Medical Expenses.

63. **Vision Care.** Expenses for vision care, including routine eye exams, professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices will not be considered eligible. However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an intraocular lens following cataract Surgery. This exclusion does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages and as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

64. **War.** Expenses for the treatment of Illness or Injury resulting from a war or any act of war or terrorism, whether declared or undeclared, civil war, hostilities or invasion, or while in the armed forces of any country or international organization will not be considered eligible.

65. **Weekend Admissions.** Expenses for care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or Saturday will not be considered eligible, unless Surgery is scheduled within 24 hours.

66. **Worker's Compensation.** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Participant would be entitled to compensation under any Worker's Compensation Law or occupational disease law or similar legislation will not be considered eligible.

This exclusion does not apply if the Participant is not actually covered by Worker's Compensation or similar law unless such coverage is required by applicable law but was not in force for the Participant.

Expenses for Injuries or Illness which were eligible for payment under Worker's Compensation or similar law and have reached the maximum reimbursement paid under Worker's Compensation or similar law will not be eligible for payment under this Plan.

ARTICLE XVII
PRESCRIPTION DRUG CARD PROGRAM

Express Scripts administers the prescription drug card program. Covered Prescription Drugs are subject to the cost-sharing provisions described in the Prescription Drug Schedule of Benefits unless the drug qualifies as a Preventive Drug under the Affordable Care Act, as described below.

17.01 Covered Expenses

Eligible expenses include Prescription Drugs and medicines prescribed in writing by a Physician and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an Illness or Injury, including but not limited to:

1. Legend drugs;
2. Over the Counter (OTC) drugs for heartburn/reflux (requires a prescription written specifically for the OTC drug);
3. Insulin and insulin syringes;
4. Diabetic supplies (test strips);
5. Injectable medications and syringes;
6. Growth hormones (with prior authorization);
7. Fluoride product (when coverage is required by the Affordable Care Act);
8. Injectable migraine medications;
9. Allergy emergency kits;
10. Acne treatments (prior authorization required after age 24);
11. Prenatal vitamins;
12. Fertility drugs (with prior authorization);
13. Birth control pills and other prescription contraceptives, including IUDs and implants (IUDs and implants are also covered under the medical benefit);
14. Diet control/weight management drugs;
15. Preventive Over-the-Counter (OTC) and generic drugs (including those that are considered Preventive Drugs) for patients who meet the requirements stated below under Preventive Drugs;
16. Ostomy supplies, beginning June 1, 2018 (also covered under the medical benefit);
17. Impotence drugs (with prior authorization);
18. Smoking cessation products, generally limited to a 180 day supply in a 365 day period.
    a. Zyban or Chantix;
    b. Nicotine replacement products.

    Over-the-counter (OTC) medications require a prescription from your Physician.

Vaccines Covered Under the Prescription Drug Card Program
Certain vaccines are covered under the Prescription Drug Card Program. These will be covered at Express Scripts Participating Pharmacies at 100% when they qualify as recommended Preventive Drugs under the Affordable Care Act guidelines. These vaccines are also covered at 100% under the medical benefit. Please refer to the Wellness Benefit page in your Schedule of Benefits.

17.02 Exclusions

1. Biological serums (immunological vaccines);
2. Cosmetic agents;
3. Non-Drug items, such as stockings or devices, even if a prescription is required, except as stated above;
4. Experimental drugs or drugs required to be labeled "Caution – Limited by Federal Law to Investigational Use";
5. Over the Counter (OTC) drugs (except as stated above);
6. Hair growth stimulants;
7. Refills obtained more than one year after the original prescription date or prior to 75% of completion of the projected usage;
8. Medical devices/supplies (unless listed as covered);
9. Diagnostic agents (test kits);
10. Syringes and needles (except for insulin and other covered injectables);
11. Most compound drugs, except certain drugs used for compounding hormone therapy produces and solid dosage forms (tablets and capsules) within certain classes of drugs;
12. Vitamins, except prenatal vitamins and vitamins for which coverage is required under Affordable Care Act guidelines.
13. Drugs excluded from Express Scripts' Preferred Formulary, as described below.

NOTE: Coverage, limitations and exclusions for Prescription Drugs purchased under the Prescription Drug Card Program will be determined in accordance with the Express Scripts program elected by the Plan Sponsor and will not be subject to any limitations and exclusions under the medical benefit component of the Plan. If you have questions about whether a drug is covered or any exclusions or limitations that may apply, go to the Express Scripts website at www.express-scripts.com or use the Express Scripts mobile app. Information about how to use the mobile app is posted on the Trust website or visit www.express-scripts.com. You may also contact Express Scripts customer service at 1-800-706-1754 with your questions.

17.03 Prescription Management Programs

Supply Limits / Drug Quantity Management (DQM)
When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is generally a 30-day supply. To purchase more than a 30-day supply of any drug you must use a retail pharmacy participating in Express Scripts' 90-day retail pharmacy network or the Home Delivery (mail order) program. In that case the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

Certain Prescription Drugs are subject to Drug Quantity Management (DQM) rules which further limit the quantity that can be dispensed based on manufacturer-recommended guidelines and clinical literature. For further information, refer to the DQM Frequently Asked Questions posted on the Trust website at www.egtrust.org.

Maintenance Drugs
Certain drugs that patients take for chronic medical conditions are classified by Express Scripts as maintenance drugs. You may buy up to 2 30-day fills of a maintenance drug at any retail pharmacy. After the first 2 fills, you can only buy the maintenance drug through Home Delivery or from a participating 90-day retail pharmacy. You cannot use other retail pharmacies for a maintenance drug after the first 2 fills. When you purchase a new maintenance drug you will receive a notice informing you of the 90-day retail and Home Delivery options for maintenance drugs. You will pay higher Copays if you choose to use participating 90-day retail pharmacies instead of Home Delivery.

Dispense As Written
If the Participant or Physician chooses a Brand Drug rather than the Generic equivalent when a Generic equivalent is available, the Participant will be responsible for the cost difference between the Generic Drug and the Brand Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum. The requirement to pay the difference in cost may be waived if there is a documented medical reason the patient cannot take the Generic equivalent. Your physician must contact Express Scripts to request a waiver.

Prior Authorization (PA)
The Plan requires prior authorization (PA) of certain drugs to ensure a prescription is suitable for the intended use and is being used appropriately. Express Scripts will reach out to your physician for additional information when a drug requires prior authorization. For more information, see the Frequently Asked Questions About Prior Authorization posted on the Trust website.

You have the right to request a review of any decision not to cover a medication prescribed for you, whether the decision is based on clinical guidelines or the Plan's benefit design. Contact Express Scripts at 1-800-706-1754 for information.

Step Therapy
The Plan uses step-therapy programs for certain classes of medications. For new prescriptions in these drug classes, you must try a "step-one" drug (generally a Generic drug) first. If the step-one drug does not work for you, you may obtain a step-2 drug in the same class. Your pharmacist will notify you if a new prescription is subject to step-therapy. A notice with helpful information about step therapy is posted on the Trust website. You may also contact Express Scripts at 1-800-706-1754 with questions about step therapy.

Keenan Pharmacy Care Management Program (KPCM)
This program was implemented effective January 1, 2018. Independent KPCM physicians review the Plan's prescription drug claims to identify potential opportunities for savings by substituting clinically effective alternative drugs. This is often the case, for example, when new Brand Drugs are introduced that are not much different from drugs already on the market but are priced significantly higher. If an opportunity is identified, the KPCM physician will reach out to your treating physician to recommend changing the prescribed drug. If the treating physician agrees, you will be contacted and your physician will issue a new prescription for the alternative drug. No change will be made if your treating physician does not agree to prescribe the alternative drug or if you object to the change.

Injectable Drugs
For covered injectable drugs other than insulin, you will be required to pay the applicable Copay and an additional 3% of the drug cost. The extra 3% does not apply to insulin.

Expenses for injectables that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under the Plan's medical benefit subject to any applicable medical Deductibles and Coinsurance as well as any coverage limitations and exclusions applicable to

the medical component of the Plan. Please refer to the Eligible Medical Expenses and General Exclusions and Limitations sections of this document.

Specialty Pharmacy Program
Certain very high cost oral, injectable and infused medications are classified as specialty drugs. Specialty drugs are generally limited to a 30-day supply. Specialty drugs can only be purchased from Accredo, Express Scripts' specialty pharmacy which provides patient education and assistance with the use of these drugs. If you attempt to fill a script for a specialty drug at a retail pharmacy, you will be notified that the drug must be ordered from Accredo. Self-administered injectable drugs available under the Prescription Drug Card Program generally will not be reimbursed under the medical benefit component of the Plan. The Specialty Drug List is posted on the Trust website at www.egtrust.org. This list will change from time to time.

SaveonSP Specialty Copay Assistance Program
Effective September 1, 2018 the Plan is implementing SaveonSP, a specialty drug Copay assistance program for a limited number of specialty drugs. The Plan charges higher Copays for these drugs, but if you enroll in the SaveonSP Copay assistance program your Copay costs will be covered by the drug manufacturer at no cost to you. These drugs are considered non-Essential Health Benefits under the Plan and the Copay costs paid by the manufacturer will not count toward your Out-of-Pocket Maximum or ACA Maximum. If you take one of the targeted drugs you will receive a letter or phone call asking you to contact SaveonSP to enroll so you can take advantage of the Copay assistance program. A list of the specialty drugs covered by this program and the corresponding Copays will be posted on the Trust website at www.egtrust.org. You may also call SaveonSP at 800-683-1074. This program is currently not available to Participants in any of the high deductible health plans (Plan HDHP and the H plans).

17.04 Definitions

Brand-name Drug or Brand Drug. A trade name medication.

Generic Drug. A Prescription Drug which has the equivalency of the Brand Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Non-Preferred Drug. Any Brand-name Drug that does not appear on the Preferred Formulary list.

Preferred Drug Formulary. A list of preferred drugs that has been developed by a Pharmacy and Therapeutics Committee comprised of Physicians, Pharmacists and other health care professionals. The list of drugs is subject to periodic review and modification based on a variety of factors such as, but not limited to, Generic Drug availability, Food and Drug Administration (FDA) changes, and clinical information. Express Scripts can provide a list of preferred drugs available. The most recent Preferred Formulary list is also on the Trust website at www.egtrust.org and at www.express-scripts.com.

Excluded Drugs. Certain drugs are excluded from the Formulary because equally effective and safe alternatives are available. In most cases, if you fill a prescription for an excluded drug you will pay the full price. A list of Formulary Exclusions with the preferred alternative drugs is included at the end of the Preferred Formulary list of drugs on the Trust website at www.egtrust.org and at www.express-scripts.com. If you are unable to take the alternative, your Physician may request an exception through the prior authorization process.

Prescription Drug. Any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, "Caution: federal law prohibits dispensing without prescription"; (b) a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law); (c) injectable insulin; or (d) hypodermic needles or syringes, but only when dispensed from a licensed dispenser upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury or a covered Preventive Drug.

Over the Counter (OTC) Drugs. The following over-the counter (OTC) drugs for heartburn/reflux are covered by the Plan at 100% under the prescription card benefit with no member Copay: Famotidine (Pepcid), omeprazole OTC (Prilosec OTC), Lansoprazole OTC (Prevacid OTC); ranitidine (Zantac), Nexium 24 hour OTC. You must submit a prescription written specifically for the OTC drug.

Preventive Drugs Covered under ACA at 100%. Certain drugs which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service are covered with no member cost-sharing if the patient meets conditions stated in the guidelines. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/coverage/preventive-care-benefits/

For a paper copy, please contact the Third Party Administrator or Express Scripts. If the patient meets the applicable guidelines, ACA Preventive Drugs include, but are not limited to: aspirin, fluoride, folic acid, medications to prepare for a colonoscopy, contraceptives (as described below), and smoking cessation products You must submit a prescription written for the applicable drug. Please contact Express Scripts for a complete list of the Preventive Drugs this Plan covers under the ACA with no cost-sharing and any restrictions on the available drugs.

Preventive Contraceptives. Coverage for preventive contraceptives and contraceptive devices is only available for women of child bearing age. Brand name contraceptives that have a Generic equivalent are covered at 100% only when the prescriber indicates that the Brand product must be dispensed. The term Preventive Drug does not include abortifacient drugs or over-the-counter contraceptives (other than FDA approved over-the counter emergency contraceptives) regardless of whether or not such items are prescribed by a Physician.

To the extent the above does not cover any Preventive Drug or contraceptive device required by the ACA to be covered under guidelines issued by the U.S. Department of Health Human Services (HHS) or the Health Resources and Services Administration (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services), the above shall be deemed to be amended to cover such Preventive Drug or contraceptive device to the extent required by HHS and/or such guidelines.

Preventive Drugs for Plan HDHP. Under IRS rules, Participants in high deductible health plans must generally satisfy the Calendar Year Deductible before any services are covered by the Plan. Therefore, in Plan HDHP you must pay 100% of the discounted cost for your Prescription Drugs until you meet the Deductible, with two exceptions:

1. You can obtain ACA Preventive Drugs (described above) with no cost sharing without meeting the Deductible. The ACA Preventive Drug exception also applies for the H Plans.

2. High deductible plans are also permitted to cover certain other Preventive Drugs before the Deductible is satisfied. In Plan HDHP you can purchase these other drugs for the applicable prescription drug Copay before you meet the Deductible. The most commonly prescribed Preventive Drugs permitted to be covered before the Deductible in high deductible health plans are listed in the Consumer Directed Healthcare (CDH) Preventive Medicine List posted on the Trust website at www.egtrust.org. This is a different and much longer list than the Preventive Drugs required to be covered under the ACA. This second exception does not apply in the H Plans.

ARTICLE XVIII
HIPAA PRIVACY

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of our Notice of Privacy Practices are available by calling 1-800-397-9598.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Plan Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan. The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The Participant's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to PHI;
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Establish safeguards for information, including security systems for data processing and storage;

4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

6. Not use or disclose genetic information for underwriting purposes;

7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);

10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);

11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);

12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

13. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

14. Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

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

16. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    (a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed: the Privacy Officer, the officers of the Plan Sponsor and members of the Appeals Committee. The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
    (b) In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose

reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor
The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor may authorize and direct the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Permissible Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant's information.

3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Other Permissible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

    (a) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

(b) report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
(c) locate and notify persons of recalls of products they may be using; and
(d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

3. Other Victims of Abuse, Neglect or Domestic Violence: Except for reports of child abuse or neglect permitted by 2(a) above, the Plan may disclose PHI to a government authority when required or authorized by law, or with the Participant's agreement, if the Plan reasonably believes the Participant to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.

6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

7. Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years.

8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.

9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

11. Inmates: The Plan may disclose PHI to a correctional institution or law enforcement official for the institution to provide health care to the Participant, the Participant's health and safety or the health and safety of others, or the safety and security of the correctional institution.

12. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

13. Emergency Situations: The Plan may disclose PHI in an emergency situation, or if the Participant is incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. The Plan will use professional judgment and experience to determine if the disclosure is in the Participant's best interest. If the disclosure is in the Participant's best interest, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the Participant's care.

14. Fundraising Activities: The Plan may disclose PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If the Plan does not contact the Participant for fundraising activities, the Plan will give the Participant the opportunity to opt-out, or stop, receiving such communications in the future.

15. Group Health Plan Disclosures: The Plan may disclose PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to the Participant. The Plan can disclose PHI to that entity if that entity has contracted with the Plan to administer the Participant's health care program on its behalf.

16. Underwriting Purposes: The Plan may disclose PHI for underwriting purposes, such as to make a determination about a coverage application or request. If the Plan does not disclose the Participant's PHI for underwriting purposes, the Plan is prohibited from using or disclosing in the underwriting process the PHI that is genetic information.

Uses and Disclosures of PHI that Require Authorization

1. Sale of PHI: The Plan will request written authorization before it makes any disclosure that is deemed a sale of PHI, meaning the Plan is receiving compensation for disclosing the PHI in that manner.

2. Marketing: The Plan will request written authorization to use or disclose PHI for marketing purposes with limited exceptions, such as when the Plan has face-to-face marketing communications with the Participant or when the Plan provides promotional gifts of nominal value.

3. Psychotherapy Notes: The Plan will request written authorization to use or disclose any of the Participant's psychotherapy notes that may be on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of PHI that are not described above will be made only with written authorization. If the Participant provides the Plan with such authorization, it may be revoked in writing and the revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that the Plan already used or disclosed, relying on the authorization.

Required Disclosures of PHI

1. Disclosures to Plan Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Participant.

2. Disclosures to the Secretary of the U.S. Dept. of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Potential Impact of State Law

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

Rights of Individuals

The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

2. Right to Receive Confidential Communication: The Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and explain how the Participant would like to be contacted. The Plan will accommodate all reasonable requests.

3. Right to Receive a Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the Plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the 6 years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Compliance Coordinator.

5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.

6. Amendment: The Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

7. Fundraising contacts: The Participant has the right to opt out of fundraising contacts.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Compliance Coordinator Contact Information:

Privacy Officer
c/o HealthSCOPE Benefits, Inc.
27 Corporate Hill Drive
Little Rock, AR 72205
Phone: 1-800-397-9598

ARTICLE XIX
HIPAA SECURITY

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that the Plan creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions
"Electronic Protected Health Information" (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

"Security Incidents" is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations
To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.

3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate report to the Plan any security incident of which it becomes aware.

4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI
The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the Participant whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Breach Notification must be provided to individual by:
    a. Written notice by first-class mail to Participant (or next of kin) at last known address or, if specified by Participant, e-mail;
    b. If Plan has insufficient or out-of-date contact information for the Participant, the Participant must be notified by a "substitute form;
    c. If an urgent notice is required, Plan may contact the Participant by telephone.

    The breach notification will have the following content:
    a. Brief description of what happened, including date of breach and date discovered;

b. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
c. Steps the Participant should take to protect from potential harm;
d. What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches.

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.

3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each calendar year.

4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.