

**WESTERN AREA SCHOOL
HEALTH BENEFIT PLAN**

RED PLAN BOOKLET

Effective Date: October 1, 2018

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

Beardstown Community Unit School District #15
Camp Point Central Community Unit School District #3
Dallas Elementary School District #327
Fulton County Community Unit School District #3, Cuba
Havana Community Unit School District #126
Illini West High School District #307
La Harpe Community School District #347
Liberty Community Unit School District #2
Mendon Community Unit School District #4
Midwest Central Community Unit School District #191
Payson Community Unit School District #1
Pikeland Community Unit School District #10
Pleasant Hill Community Unit School District #3
Regional Office of Education #1
Regional Office of Education #26
Regional Office of Education #33
Regional Office of Education #53
Schuyler-Industry Community Unit School District #5
Southeastern Community Unit School District #337
Spoon River Valley Community Unit District #4
VIT Community Unit School District #2
Warsaw Community Unit School District #316
West Central Community Unit School District #235
West Central Illinois Special Education Cooperative (WCISEC)
West Prairie Community Unit School District #103
Western Area Career System #265

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BENEFIT PLAN SUMMARY DESCRIPTION

1. NAME OF PLAN:
Western Area School Health Benefit Plan
2. NAME, ADDRESS & TELEPHONE NUMBER OF PLAN SPONSOR, PLAN ADMINISTRATOR, AND AGENT FOR SERVICE OF PROCESS:
Western Area School Association
c/o MidAmerica National Bank
P. O. Box 1300
130 N. Side Square
Macomb, Illinois 61455
(309) 833-4111
3. PLAN COORDINATOR:
Plan Sponsor
4. PLAN EMPLOYER IDENTIFICATION NUMBER:
Trust Federal Identification Number: 37-1181316
Plan Number: 501-8491
Federal Health Plan Identification Number: 7770587047
5. TYPE OF WELFARE PLAN:
Major Medical Plan
Prescription Drug Plan
Dental Plan
Vision Plan
6. TYPE OF ADMINISTRATION OF THE PLAN:
Contract Administration
7. NAME, ADDRESS & TELEPHONE NUMBER OF THIRD PARTY ADMINISTRATOR:
Consociate, Inc.
2828 N. Monroe
P.O. Box 1068
Decatur, IL 62525-1068
(217) 423-7788
(800) 798-2422
8. NAME, ADDRESS & TELEPHONE NUMBER OF PLAN ADMINISTRATOR:
Western Area School Association
c/o MidAmerica National Bank
P. O. Box 1300
130 N. Side Square
Macomb, Illinois 61455
(309)833-4111
9. NAME AND ADDRESS OF TRUST:
Western Area School Employee Benefits Trust
c/o MidAmerica National Bank
P. O. Box 1300
130 N. Side Square
Macomb, Illinois 61455
(309) 833-4111

10. ORIGINAL PLAN EFFECTIVE DATE: SEPTEMBER 1, 1984
Plan Anniversary Date: September 1

ORIGINAL PLAN EFFECTIVE DATE WITH THIRD PARTY ADMINISTRATOR:
March 1, 2008

EFFECTIVE DATE OF THIS DOCUMENT: October 1, 2018

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

11. PLAN YEAR:
September 1 to August 31

12. PLAN BENEFITS:
Plan benefits are described in this document.

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

14. FUNDING MEDIUM:
The Plan is self-funded from employers and/or covered person's contributions. Benefit payments are made pursuant to the Plan provisions from the contributions which have been placed in the Trust.

MEDICAL SCHEDULE OF BENEFITS

**MEDICAL SCHEDULE OF BENEFITS
RED PLAN**

Calendar Year Deductible Per Person		Calendar Year Deductible maximum per Family		Calendar Year Out-of-Pocket* per Person		Calendar Year Out-Of-Pocket* maximum per Family	
PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
\$1,000		\$3,000**		\$2,500	\$5,000	\$6,250	\$15,000
\$2,000		\$6,000**		\$3,500	\$9,000	\$6,500	\$21,000
\$3,000***		\$6,000****		\$3,000	\$6,000	\$6,000 [†]	\$12,000 [†]

*Excludes Deductible with the exception of the Health Savings Account Option. Individual calendar year out-of-pocket amounts will count toward the family out-of-pocket amount, but an individual will not have to pay more than the individual out-of-pocket amount, except with the Health Savings Account Option.

** Individual deductible amounts will count toward the family deductible, but the individual will not have to pay more than the individual deductible. Deductible amounts for PPO and Non-PPO are separate and do not accumulate toward each other.

***Health Savings Account Option.

****The entire family deductible must be met before the Plan's coinsurance applies

[†]The entire family out-of-pocket must be met before the Plan pays at 100%

Out-of-Pocket amounts for PPO and Non-PPO are separate and do not accumulate toward each other.

During the annual open enrollment period (August 15th through September 15th annually), individuals with existing coverage and late entrants without coverage, will have the opportunity to enroll for coverage in one of the deductible option subplans as stated above. This change will go into effect on October 1st of the same year. New hires who desire coverage or families of special enrollees with coverage will also have the opportunity to choose one of the deductible option subplans as stated above at the time of enrollment or special enrollment.

There will be an additional period of time that individuals with coverage can change their deductible option subplan including moving to the Health Savings Account Option. This time period is during the month of December with any resultant change in coverage becoming effective on the next January 1. The \$1,000 deductible option subplan is the default option if no different option is selected. All family members must participate in the same deductible option subplan. A deductible option subplan once selected shall remain in effect until changed in accordance with the foregoing. An individual may not select a deductible option subplan except in accordance with the foregoing.

The health savings account deductible option subplan is designed to be used if a health savings account is utilized. If this option is selected then all Plan benefits are payable at 100% at a PPO after satisfaction of the deductible, except that all Preventive Health Services and up to \$500 in other routine wellness benefits otherwise payable by the Plan are payable before application of the deductible. In addition, routine mammograms and breast ultrasounds will be paid without application of the deductible even if the cost exceeds the \$500 wellness benefit amount. The Non-PPO cost sharing percentage or coinsurance benefit will be the same percentage as stated elsewhere in the Red Plan Schedule of Benefits.

FIRST DOLLAR BENEFITS	CO-INSURANCE/LIMITS, (if any)	
	Deductible applies unless otherwise stated	
	PPO	Non-PPO
Second Surgical Opinion (and Third Surgical Opinions, when necessary)	100% no deductible	50% of Provider's reasonable charge after deductible
Routine Mammograms, limited to one (1) per calendar year unless risk factors present	100% no deductible	
Routine gynecological examinations, routine pap smears and laboratory charges directly associated with routine pap smear. Coverage is for all covered persons and eligible dependents and limited to one (1) exam per calendar year	100% no deductible	50% of Provider's reasonable charge after deductible
Annual Digital Rectal Examination including associated doctor's office visit and laboratory charges directly associated with digital rectal examination, limited to one (1) exam per calendar year	100% no deductible	50% of Provider's reasonable charge after deductible
Routine Prostatic Specific Antigen ("PSA") Test including associated doctor's office visit and laboratory charges directly associated with routine PSA, limited to one (1) exam per calendar year	100% no deductible	50% of Provider's reasonable charge after deductible
Routine colonoscopy including associated doctor's visit and laboratory charges directly associated with the colonoscopy for covered persons age 50 or over, limited to one (1) per five (5) years	100% no deductible	50% of Provider's reasonable charge after deductible
Colorectal Cancer Exam and screening – limited to once every three (3) years for persons age fifty (50) and over	100% no deductible	50% of Provider's reasonable charge after deductible
Osteoporosis Bone Mass Testing, Measurement, and Treatment	100% no deductible	50% of Provider's reasonable charge after deductible
Comprehensive Breast Ultrasound	100% no deductible When Medically Necessary	
Well Child Care from birth to age two (2) – including office visits and labs directly associated with the wellness care. Immunizations are covered from birth to age eighteen (18) months. See Preventive Health Services benefit for immunizations after eighteen (18) months.	100% no deductible	50% of Provider's reasonable charge after deductible

<p>Wellness Office Visit. All other treatments or services received during the office visit are subject to other Plan provisions as described in this Medical Schedule of Benefits</p>	<p>100% no deductible</p>	<p>50% of Provider's reasonable charge after deductible</p>
<p>Preventive Health Services required by the Affordable Care Act, as follows:</p> <p>Evidence based items or preventive services that have an "A" or "B" rating from the United States Preventive Services Task Force; Immunizations recommended by the Advisory Committee on Practices of the Centers for Disease Control and Prevention; Evidence-informed preventive care services and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents; Additional Preventive care and screenings not described above as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for women; and The current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention, other than those issued in or around November 2009.</p>	<p>100% no deductible</p>	<p>50% of Provider's reasonable charge after deductible</p>

MAJOR MEDICAL BENEFITS: The benefits in the section below are payable at the applicable PPO/Non-PPO co-insurance rate (unless otherwise stated) and are subject to the calendar year deductible (unless otherwise stated). The Plan will pay eligible charges in excess of the calendar year deductible (if applicable) incurred at or by a HealthLink Open Access Provider at 90%, and at or by any other PPO Provider at 80%, and the Plan will pay eligible charges in excess of the calendar year deductible (if applicable) incurred at or by a Non-PPO Provider at 50%. The only exception to these co-insurance rates is that, for services or treatment received in Iowa, the co-insurance rate for a HealthLink Open Access Provider or other PPO Provider is 80% and the co-insurance rate for a Non-PPO Provider is 50%. Any limitations stated are for PPO and Non-PPO services combined.

BENEFITS/ADDITIONAL MAXIMUMS	CO-INSURANCE/ LIMITS (if any) Deductible applies unless otherwise stated		
	Healthlink Open Access PPO or HFN CHC ELITE	Other PPO	Non-PPO
Pre-admission Testing, limited to within seven (7) days of hospital admission	90% after deductible	80% after deductible	50% of Provider's reasonable charge after deductible
Routine Proctoscopy including associated doctor's office visit and laboratory charges directly associated with routine proctoscopy limited to one (1) exam per calendar year	90% after deductible	80% after deductible	50% of Provider's reasonable charge after deductible
Ovarian Cancer screening & surveillance testing	90% after deductible	80% after deductible	50% of Provider's reasonable charge after deductible
Clinical Breast Exams for Women	90% after deductible	80% after deductible	50% of Provider's reasonable charge after deductible
Human Papillomavirus Vaccine	90% after deductible	80% after deductible	50% of Provider's reasonable charge after deductible

BENEFITS/ADDITIONAL MAXIMUMS (Cont'd)	CO-INSURANCE/ LIMITS (if any)		
	Deductible applies unless otherwise stated		
	Healthlink Open Access PPO or HFN CHC ELITE	Other PPO	Non-PPO
Amino acid-based elemental formulas	90% after deductible	80% after deductible	50% of Provider's reasonable charge after deductible
<p>Primary Care Physician and Urgent Care Facility Office Visits</p> <p>Note:</p> <p>1. The office visit co-pay continues to apply to all office visits even after the covered persons have met their deductible and out-of-pocket maximums.</p> <p>2. Co-Payment applies to Office Visit charge only. All other treatments or services received during the office visit are subject to deductible and coinsurance. In addition, allergy injections received during a Physician's office visit will be covered subject to a separate Benefit. Refer to the allergy injections benefit.</p>	<p>\$35 co-pay applies, then Plan pays 100% up to a \$200 maximum, Any remaining balance is paid at 90% after deductible</p>	<p>\$35 co-pay applies, then Plan pays 100% up to a \$200 maximum, Any remaining balance is paid at 80% after deductible</p>	50% after deductible
<p>Specialist Physician Office Visits</p> <p>Note:</p> <p>1. The office visit co-pay continues to apply to all office visits even after the covered persons have met their deductible and out-of-pocket maximums.</p> <p>2. Co-Payment applies to Office Visit charge only. All other treatments or services received during the office visit are subject to deductible and coinsurance. In addition, allergy injections received during a Physician's office visit will be covered subject to a separate Benefit. Refer to the allergy injections benefit.</p>	<p>\$50 co-pay applies, then Plan pays 100% up to a \$200 maximum, Any remaining balance is paid at 90% after deductible</p>	<p>\$50 co-pay applies, then Plan pays 100% up to a \$200 maximum, Any remaining balance is paid at 80% after deductible</p>	50% after deductible
<p>Outpatient Surgery and associated x-ray and laboratory supplies (when performed on the same day as the surgery) when performed in an ambulatory surgical facility, outpatient facility of a hospital, or a physician's office.</p>	85% after deductible	85% after deductible	50% of Provider's reasonable charge after deductible

BENEFITS/ADDITIONAL MAXIMUMS (Cont'd)	CO-INSURANCE/LIMITS (if any) Deductible applies unless otherwise stated		
	Healthlink Open Access PPO or HFN CHC ELITE	Other PPO	Non-PPO
Physical Therapy Services-Outpatient (25 treatment sessions per sickness or injury maximum. If the attending Physician feels that it is Medically Necessary for a Covered Person to receive more than 25 treatments, the attending Physician must receive Plan approval for the additional treatments in order for those treatments to be covered).	90% after deductible	80% after deductible	50% of Provider's reasonable charge after deductible
Speech Therapy-Outpatient (Benefit is limited to the developmental delay for children between the ages of 0-6) (25 treatment sessions per sickness or injury maximum. If the attending Physician feels that it is Medically Necessary for a Covered Person to receive more than 25 treatments, the attending Physician must receive Plan approval for the additional treatments in order for those treatments to be covered).	90% after deductible	80% after deductible	50% of Provider's reasonable charge after deductible
Occupational Therapy-Outpatient (25 treatment sessions per sickness or injury maximum. If the attending Physician feels that it is Medically Necessary for a Covered Person to receive more than 25 treatments, the attending Physician must receive Plan approval for the additional treatments in order for those treatments to be covered).	90% after deductible	80% after deductible	50% of Provider's reasonable charge after deductible
Renal Dialysis Charges are subject to deductible and co-insurance amounts and payment will not exceed 100% of the Medicare allowed amount as determined by Ethicare Advisors for dialysis and outpatient dialysis for Open Access PPO, PPO, and Non-PPO providers.	90% after deductible	80% after deductible	50% of Provider's reasonable charge after deductible
Extended Care/Skilled Nursing Facility (Care must begin within 14 days of hospital confinement of at least three (3) consecutive days)	50% after deductible	50% after deductible	50% of Provider's reasonable charge after deductible
Home Health Care 40 days per calendar year limit	90% after deductible	80% after deductible	50% of Provider's reasonable charge after deductible
Emergency Services at Emergency Room (copay continue to apply after the out-of-pocket maximum is met to the extent allowed by law)	\$150 co-pay visit, then 90% after deductible	\$150 co-pay visit, then 90% after deductible	\$150 co-pay visit, then 90% after deductible
Non-Emergency Services at Emergency Room (copay continue to apply after the out-of-pocket maximum is met to the extent allowed by law)	\$150 co-pay visit, then 90% after deductible	\$150 co-pay visit, then 80% after deductible	\$150 co-pay visit, then 50% after deductible

BENEFITS/ADDITIONAL MAXIMUMS (Cont'd)	CO-INSURANCE/LIMITS (if any) Deductible applies unless otherwise stated		
	Healthlink Open Access PPO or HFN CHC ELITE	Other PPO	Non-PPO
Hearing Aids for dependent children through age 18, limited to \$2,000 per ear per calendar year and further limited to 1 hearing aid every 3 years	90% after deductible	80% after deductible	50% of Provider's reasonable charge after deductible
Chiropractic care Limited to \$1,000 payable per calendar year	90% after deductible	80% after deductible	50% of Provider's reasonable charge after deductible
<u>Transplant Procedures:</u> Benefits payable at co-insurance levels described below, if covered. Expenses incurred for organ procurement from a non-living donor per transplant limited to \$10,000 per transplant. Expenses incurred for organ procurement from a living donor per transplant limited to \$25,000 per transplant. Expenses incurred for transportation, lodging, and meals combined cannot exceed \$200 per day and \$10,000 per transplant (For one (1) adult or two (2) adults if the covered recipient/donor is a minor) Overall Transplant Procedure Limit Per Transplant in \$1,000,000. Notwithstanding the PPO provisions of the Plan, the only PPO hospital providers for organ and tissue transplants (other than for non-living donor charges) are the Centers of Excellence network of transplant hospitals that the Plan Administrator has contracted with to provide transplant services.	80% after deductible	80% after deductible	Not Covered
All other covered expenses except Health Savings Account Option or unless stated otherwise.	90% after deductible	80% after deductible	50% of Provider's reasonable charge after deductible

NOTE: Precertification is the Covered Person's responsibility and is required for all hospitalizations, outpatient surgery requiring anesthesia, skilled nursing or rehab facility stays, transplant services, home health or hospice care, dialysis, cardiac rehabilitation, chemotherapy and radiation therapy, PET scan, MRI and CT scans, pre-natal and maternity care, DME over \$500, speech, physical and occupational therapy, and mental illness and substance abuse treatment. The precertification call must be made at least 72 hours prior to an elective procedure or admission or within 72 hours after an emergency procedure or admission. Failure to call or failure to follow the procedures and recommendations of AIMM will result in the application of an

additional penalty in the amount of the lesser of 20% of the covered charges or \$1,000. Penalties applied due to failure to comply with the procedures and recommendations of the Utilization Review Program will not apply to the out-of-pocket and will never increase to 100%.

The telephone number for pre-certification is:
AIMM (877) 217-7695

NOTE: The Preferred Provider Organizations for the Plan are:

HealthLink Open Access PPO III
(800) 624-2356
(314) 989-6300
www.healthlink.com

HFN CHC Elite Network
(800) 295-5444
www.hfninc.com

The HealthLink Network is available for all covered persons in all places except Peoria, Knox, and Tazewell Counties. Covered Persons must select which of the above two Preferred Provider Organization (PPO) Networks they would like as their PPO network for those three counties. Network selection can be made at the time a covered person family member is initially enrolled in the Plan, during a special enrollment period, during an open enrollment period (effective as of October 1), or during the month of December (effective as of January 1). A selection may not be made or changed at any other time and must be identical for all family members. HealthLink shall be the default network in the event the primary covered person has not made a selection. In addition, the following providers will be considered Preferred Providers:

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

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

1. Emergency services provided in connection with Hospital emergency treatment obtained at a Non-PPO Hospital shall be considered to be provided by a PPO for all Plan purposes until the patient's condition has stabilized to the degree as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from the transfer to a Non-PPO Hospital.
2. Non-PPO Emergency treatment rendered at a PPO facility (this includes the ER physician charges). If the covered person is admitted to the hospital after such emergency treatment, covered expenses shall be payable at the PPO level. Follow-up care after discharge from the hospital will be payable at the applicable PPO/Non-PPO level of benefits.
3. Non-PPO anesthesiologist if the operating surgeon or hospital is a PPO.
4. Radiologist or pathologist services for interpretation of x-ray and laboratory tests rendered by a Non-PPO provider when the facility rendering such services is a PPO provider.
5. While confined to a PPO hospital, the PPO physician requests a consultation from a Non-PPO provider.
6. While obtaining services in a PPO facility, the PPO physician requests assistance from a Non-PPO provider, for example, assistant surgeon services.
7. While obtaining services in a PPO facility, the procedures are conducted by a Non-PPO outside owned entity.

**DENTAL SCHEDULE OF BENEFITS
(Effective through December 31, 2018)**

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

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

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

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

**DENTAL SCHEDULE OF BENEFITS
(Effective January 1, 2019)**

DENTAL EXPENSE BENEFITS	
Calendar year deductible per person	\$50
Calendar year maximum benefit payable per person	\$500
Lifetime maximum benefit payable per person for orthodontia care	\$1,000
CLASS OF BENEFITS	CO-INSURANCE
Class I – Preventive Care (This category of benefits shall be in addition to the dental calendar year maximum)	100% no deductible
Class II – Basic Care	80% after deductible
Class III – Major Care	50% after deductible
Class IV – Orthodontia Care (This category of benefits are limited to dependent children under age 26).	50% after deductible

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

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

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

VISION SCHEDULE OF BENEFITS

Routine Eye Examinations – limited to one (1) exam per calendar year	100% no deductible after \$10 copay per visit
Glasses and Contacts – limited to maximum of \$250 every 2 calendar years	100% no deductible after \$35 copay per visit

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

PRESCRIPTION DRUG PROGRAM

PREFERRED FORMULARY PROGRAM	CO-PAYMENT
<p><u>Retail Drug Program:</u> (Up to a 34-day supply of a covered prescription drug or 90 day if Performance retail is used)</p> <p>Generic Drugs Brand Preferred Formulary Brand Non-Preferred</p>	<p>\$10.00 \$35.00 \$50.00</p>
<p><u>Mail-Away Drug Program:</u> (Up to a 90-day supply of a covered prescription drug)</p> <p>Generic Drugs Brand Preferred Formulary Brand Non-Preferred</p> <ul style="list-style-type: none"> • The Generic co-pay will no longer apply when purchasing generic prescriptions for which coverage is required as Preventive Health Services, including Women's Preventive Services. Should you choose to purchase a Brand Preferred Formulary or a Brand Non-Preferred Formulary Drug the associated co-pay list above will apply unless medically required or the generic drug does not exist. • The Generic co-pay will apply when a generic drug is requested. The Plan requires the use of generic drug when approved by your physician. If your physician approves the use of a chemically equivalent generic drug, and you choose the brand name drug, you will pay your co-pay plus the cost difference between the brand and the generic drug. • The Brand Preferred Formulary co-pay will apply when a brand-name drug, on the Preferred Formulary List, is requested. • The Brand Non-Preferred co-pay will apply when a brand-name drug, <u>not</u> on the Preferred Formulary List, is requested. 	<p>\$20.00 \$70.00 \$100.00</p>

Contact MedTrak Services at 800-771-4648 or visit their website at www.medtrakservices.com to obtain information about the new preferred formulary drug program and to get information about obtaining your prescriptions at the most cost effective co-pay.

NOTE: Eligible Prescription Drugs must be purchased by use of the MedTrak Retail Drug Card Program or the MedTrak Mail Drug Program. The Plan will not reimburse drugs purchased without use of the Prescription Drug Card or through the Mail Program. However, diabetic supplies, blood glucose meters and injectable drugs used to regulate blood glucose levels can be purchased through the Drug Card or Mail program or they can be purchased without the use of this program and submitted as a medical expense.

MEDTRAK - RETAIL DRUG CARD PROGRAM

Prescriptions can be filled by use of the MedTrak Retail Network Service, which allows you to get up to a 34-day or 90-day supply of a Prescription Drug filled at any Network Pharmacy. You present your Drug Card and pay the co-payment as stated in the Schedule of Benefits. Your Employer has a list of participating Network Pharmacies, or you can call (800) 771-4648 for additional participating Network Pharmacy information.

MEDTRAK MAIL DRUG PROGRAM

If you have a prescription for a maximum of a 90-day supply of a prescription drug, you can utilize the Mail Service Program through MedTrak Services.

Benefits are payable, as stated in the Schedule of Benefits, when a person incurs expenses for a prescribed drug ordered through MedTrak Services. You can call (between the hours of 8 a.m. and 12 midnight EST) at (800) 771-4648 with mail-away questions.

STEP THERAPY PROGRAM

Prescription drug program benefits for certain expensive drugs are subject to the step therapy program in order to be covered by the Plan. In the step therapy program, drugs are grouped in categories, based on cost effectiveness:

Front-line drugs – the first step – are generic drugs proven safe, effective and affordable. These drugs should be tried first because they can provide the same health benefit as more expensive drugs, at a lower cost.

Back-up drugs – Step 2 and Step 3 drugs – are brand name drugs. These are lower-cost brand drugs (Step 2) and higher-cost brand drugs (Step 3). Back-up drugs always cost more than front-line drugs.

Step Therapy means that certain prescriptions require the use (and treatment failure) of front-line drugs before coverage may be allowed for a prescription of a back-up drug. **If you are taking a backup drug on December 31, 2010 and are compliant on your medication, you will not be required to try a front line drug.**

When a prescription is submitted that is not for a front-line drug, your pharmacist will let you know, and your cost will be higher. If you prefer not to pay the full price for the drug prescribed, you or your pharmacist should contact your physician. Only your physician can approve and change your prescription to a first-step drug. Call MedTrak Services at 800-771-4648 to get examples of effective first-step drugs on your Plan to discuss with your physician. If your physician decides you need a different drug for medical reasons, he or she must call 800-771-4648 to request a Prior Authorization. A MedTrak representative will check your Plan's guidelines to see if a Step 2 drug can be covered. If it can, you may pay a higher copayment than for a front-line drug. If it cannot be covered, you may need to pay the full price for the drug. Additional program details are available from MedTrak and the Third Party Administrator.

CO-PAYMENT ASSISTANCE PROGRAM

For certain classes of Specialty Drugs (e.g., medications treating conditions such as multiple sclerosis, rheumatoid arthritis, hepatitis c and antiretrovirals), if dispensed through a pharmacy in MedTrak's Best-In-Class Specialty Pharmacy Network, and where the drug manufacturer offers one or more co-payment assistance programs to help pay for the cost of the prescription, a higher co-payment than the amounts listed on the previous page may be charged; but, any such excess amounts will be billed to the drug manufacturer for payment under the applicable co-payment assistance program, and you will not have to pay out-of-pocket any more than the previously stated co-payment amount set forth.

COVERED DRUGS

1. Prescription Legend Drugs unless otherwise stated herein;
2. Over-the-counter drugs that are Preventive Health Services;
3. Single entity vitamin D2 and D3 containing 1,000IU or less per dosage form and combination products that also contain calcium, for Covered Persons age 65 or over.

4. Retin-A (tretinoin) when used for acne treatment or subsequent FDA approved indications other than for cosmetic purposes, which will not be covered.
5. Retrovir, or other similar drug classifications.
6. Birth control pills and certain similar birth control products available through the Retail Drug Plan. All other means of prescribed birth control prevention, including but not limited to injections and Norplant implants, will be payable under the Major Medical Plan.
7. Drugs for smoking cessation (either over-the-counter or generic), including Chantix, for Covered Persons age 18 and over.

EXCLUSIONS AND LIMITATIONS

The following are excluded:

1. Prescribed vitamins, however prescribed prenatal vitamins are covered;
2. Drugs, implants, injectables or devices prescribed for birth control, or weight control, except that birth control pills and certain similar birth control products are covered through the Retail Drug Plan. All other means of prescribed birth control prevention, including but not limited to injections and Norplant implants, will be payable under the Major Medical Plan.
3. The administration of prescription drugs or administration of injectable drugs used to regulate blood glucose levels;
4. Cosmetic drugs (i.e., Rogaine, Retin-A (except as stated above));
5. Fertility drugs;
6. Injectable drugs other than routine injectable drugs on the list maintained by MedTrak Services;
7. Any drug or medication that is not a covered drug;
8. Any covered drug prescribed for use by other than a covered employee or covered dependent;
9. The amount of any covered drug prescription or refill in excess of a 34-day supply (for the Retail Card Program) or a 90-day supply (for the Mail Program or Performance 90 Program) according to the directions, or in excess of 100 tablets or capsules, whichever is greater;
10. Any prescription refill of a covered drug in excess of the number specified by the physician, or which is dispensed more than one (1) year after the date the prescription was written;
11. Any covered drug which may be received without charge under any local, state or federal government program; or
12. Any covered drug that is prescribed for sickness or injury for which the covered person is required to be covered (or is actually covered) under any workers' compensation law, employers' liability law, or similar law and for which the covered person is entitled to benefits with respect to such sickness or injury under such law.

CLAIM FILING INFORMATION

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

Send Medical Claims to:

Consociate, Inc.
P.O. Box 419104
St. Louis, Missouri 63141-9104
Electronic Claim Submission
EDI Vendor #90001

Send Dental and Vision Claims and All Questions to:

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

Your Group No: C080301

Preferred Provider Organization (PPO):

Effective December 1, 2015, the Preferred Provider Organizations for the Plan shall be the HealthLink Open Access PPO III Network and the HFN CHC Elite Network. For PPO information and PPO Providers for HealthLink, call HealthLink, Inc. at (800) 624-2356 or (314) 989-6300. On the web, www.healthlink.com. For PPO information and PPO Providers for HFN, call HFN at (800) 295-5444. On the web www.hfninc.com. Provider directories are available without charge.

Utilization Review and Pre-certification:

For pre-certification, call AIMM at (877) 217-7695.

Prescription Drug Services:

MedTrak Services is the Pharmacy Benefit Manager. For questions call (800) 771-4648.

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

INTRODUCTION

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

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

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

PLAN DOCUMENT

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

PURPOSE

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

PLAN AMENDMENTS

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

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

CARE MANAGEMENT SERVICES

Care Management Services Phone Number

AIMM
(877) 217-7695

The patient or family member must call this number to receive certification of certain Care Management Services described on the Schedule of Benefits. This call must be made at least 72 hours in advance of services being rendered or within 72 hours after an emergency.

Any reduced reimbursement due to failure to follow care management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

1. Precertification of the Medical Necessity for inpatient hospitalizations.
2. Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
3. Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
4. Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

HERE'S HOW THE PROGRAM WORKS.

Precertification. Before a Covered Person enters a medical care facility on a non-emergency basis or receives other listed medical services described on the Schedule of Benefits, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a medical care facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card at least 72 hours before services are scheduled to be rendered with the following information:

1. The name of the patient and relationship to the covered Employee
2. The name, Social Security number and address of the covered Employee
3. The name of the Employer
4. The name and telephone number of the attending Physician
5. The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
6. The diagnosis and/or type of surgery
7. The proposed rendering of listed medical services

If there is an emergency admission to the medical care facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator within 72 hours of the first business day after the admission.

The utilization review administrator will determine the number of days of medical care facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the claim will be denied until medical necessity and appropriateness review is completed. If the service is deemed medically necessary and appropriate then a penalty will be applied. The penalty will be the lesser of 20% of the covered charges up to \$1,000 which will not apply to the deductible or out-of-pocket maximum.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

Truly emergent medical treatment should never be withheld in order to complete precertification (which is only one component of the Plan's coverage determination). Anytime that the health of the patient would be placed in serious jeopardy, serious impairment of bodily functions, or a serious dysfunction of a body organ or part could result from a delay in care, then care would be considered truly emergent. The medical professionals rendering care to patients are solely responsible for ensuring that care is delivered in accordance with patient needs and should never make treatment decisions, especially in truly emergent situations, based on payment related (such as precertification) issues. Please be aware that **precertification is not a guarantee of benefits, eligibility, payment, nor it is a medical treatment decision or advice.**

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the

same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

1. personal support to the patient;
2. contacting the family to offer assistance and support;
3. monitoring Hospital or Skilled Nursing Facility;
4. determining alternative care options; and
5. assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, and patient or patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

MAJOR MEDICAL BENEFITS

DEDUCTIBLE

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

FAMILY DEDUCTIBLE

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

DEDUCTIBLE FOR A COMMON ACCIDENT

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

CO-INSURANCE

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

OUT-OF-POCKET

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

All individual out-of-pocket amounts will count toward the family out-of-pocket maximum amount, but an individual will not have to pay more than the individual out-of-pocket maximum amount. Co-pays do not accumulate to the out-of-pocket maximum amount, except to the extent required by the Affordable Care Act below.

Notwithstanding anything else in the Plan to the contrary, the PPO out-of-pocket maximum for the Plan shall not exceed the amounts allowed by 42 USC §300gg-6(b). For this purpose the PPO out-of-pocket maximum shall include all deductible, co-insurance and co-pay amounts (including office visit co-pays) for care obtained from a PPO provider. Similarly, the maximum calendar year amount payable for Prescription Drug Card Program copayments shall not exceed the separate maximum amount allowed by 42 USC §300gg-6(b). Effective September 1, 2015, when combined with any integrated health reimbursement arrangement, the PPO out-of-pocket maximum for the Plan shall not exceed the amounts allowed by 42 USC §300gg-6(b). For this purpose the PPO out-of-pocket maximum shall include all deductible, co-insurance and co-pay amounts (including office visit co-pays and Prescription Drug Card Program copayments) for care obtained from a PPO provider.

COVERED MEDICAL EXPENSES

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

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

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

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

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

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

Miscellaneous hospital services including equipment, medications and supplies.

Hospital charges for covered outpatient services.

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

Anesthetics and their administration.

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

Physician's services for medical care and treatment.

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

Routine gynecological physician's office visit per year, pap smear, and laboratory services related to the pap smear, limited to one (1) examination and pap smear per calendar year.

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

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

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

Well Child Care after discharge from the hospital is covered up to age two (2). This is to include office visits and labs.

Immunization directly associated with Well Child Care are covered to age eighteen (18) months. See Preventative Health Services for coverage for additional immunizations.

Preventive Health Services.

Medical Supplies:

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

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

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

Physical Therapy by a Registered Physical Therapist.

Occupational Therapy by a Registered Occupational Therapist.

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

Allergy shots and allergy surveys.

Mammogram expenses for two and three dimensional mammograms up to the maximum stated in the Schedule of Benefits.

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

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

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

Hearing aids for dependent children through age 18, limited to \$2,000 per ear per calendar year and further limited to one hearing aid every 3 years.

Hospice Care charges as stated herein.

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

Charges incurred for elective sterilizations.

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

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

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

Transplants are covered subject to the following limitations:

1. Expenses incurred for organ procurement from a non-living donor cannot exceed \$10,000 per transplant;
2. Expenses incurred for organ procurement from a living donor cannot exceed \$25,000 per transplant;
3. Expenses incurred for transportation, lodging and meals combined cannot exceed \$200 per day and \$10,000 per transplant. This is limited to one (1) adult to accompany the patient or 2 adults if the covered recipient/donor is a minor;
4. Benefits available for transplant procedures are subject to a maximum of \$1,000,000 per transplant.
5. Notwithstanding the PPO provisions of the Plan, the only PPO hospital providers for organ and tissue transplants (other than for non-living donor charges) are the Centers of Excellence network of transplant hospitals that the Plan Administrator has contracted with to provide transplant services.

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

Participation in approved clinical trials as required by 42 USC 300gg-8.

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

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

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

Services for treatment of mental and nervous disorders, alcoholism and drug abuse.

Home Health Care charges as defined herein.

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

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

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

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

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

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

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

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

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

Coverage for all colorectal cancer examinations and laboratory tests for colorectal cancer as prescribed by a physician, in accordance with the published American Cancer Society guidelines on colorectal cancer or other existing colorectal cancer screening guidelines issued by nationally recognized

professional medical societies or federal government agencies including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

Coverage for shingles vaccines for covered persons age 60 and over.

Coverage for diagnosis and treatment of autism spectrum disorders as required by Illinois law, for covered persons under age 21.

Coverage for habilitative services for covered person under age 19 with a congenital, genetic, or early acquired disorder as required by Illinois law. No coverage is available under the Plan for those services that are solely educational in nature or otherwise paid under State or federal law for purely educational services.

Oral surgery. Oral surgery means: (1) Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth; (2) Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth; (3) Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints; (4) Surgical extraction of impacted wisdom teeth.

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

Preventative physical therapy for covered person diagnosed with multiple sclerosis.

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

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

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

2. Medically necessary supplies when prescribed by physician for:
 - a. Blood glucose monitors
 - b. Blood glucose monitors for the legally blind
 - c. Cartridges for the legally blind
 - d. Lancets and lancing devices
3. Medically necessary pharmaceuticals and supplies when prescribed by a physician for:
 - a. Injectable drugs used to regulate blood glucose levels
 - b. Syringes and needles
 - c. Test strips for glucose monitors
 - d. FDA approved oral agents used to control blood sugar, and
 - e. Glucagon emergency kits.
4. Regular foot care exams by a physician.

Birth control pills and certain similar birth control products are covered through the Retail Drug Plan. All other means of prescribed birth control prevention, including but not limited to injections and Norplant implants, will be payable under the Major Medical Plan.

MATERNITY/NEWBORN COVERAGE

MATERNITY COVERAGE

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

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

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

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

NEWBORN COVERAGE

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

DENTAL BENEFITS

DEDUCTIBLE

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

CALENDAR YEAR MAXIMUM

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

COVERED CHARGES

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

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

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

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

ALTERNATE BENEFITS

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

PRE-TREATMENT REVIEW

When the expected cost of a proposed course of treatment is \$250 or more, the covered person's dentist may submit a treatment plan to include the below before dental treatment starts, however, it is not mandatory.

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

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

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

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

LIST OF COVERED DENTAL SERVICES

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

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

CLASS I PROCEDURES - PREVENTIVE

Preventative Dental Services

1. Routine oral examinations, including diagnosis and x-rays, up to a maximum of 2 examinations per calendar year,
2. One full mouth x-ray every 36 months,
3. One bitewing x-ray series every calendar year,
4. Prophylaxis (cleaning, scaling and polishing), up to a maximum of 2 treatments per calendar year,
5. Topical fluoride application,
6. Sealants for covered dependents under age 16.

CLASS II – PRIMARY DENTAL SERVICES

Primary Dental Services

1. Fillings,
2. Extractions,
3. Endodontics,
4. Periodontics, including gingivectomy and gingivoplasty, gingival curettage, osseous surgery, surgical periodontic examination, mucogingivoplastic surgery and management of acute periodontal infection and oral lesions,
5. Anesthesia, if administered in conjunction with performance of another covered dental procedure,
6. Emergency treatment for relief of pain,
7. X-rays other than bitewings and full mouth x-rays.

CLASS III – MAJOR DENTAL SERVICES

Major Dental Services

1. Inlays, onlays and crowns,
2. Charges for installing for the first time, or for adding to, a denture or fixed bridge if:

- a. The work is needed due to extraction of injured or diseased natural teeth and is finished within 12 months of the date the tooth was extracted; and
 - b. The tooth is extracted while the patient is covered for these benefits; and
 - c. The work includes replacing the extracted tooth.
- A denture or bridge is considered to be installed for the first time if it does not replace any existing denture or bridge.
- 3. Charges for replacing or altering a denture or fixed bridge if:
 - a. The change is needed due to one of these events:
 - i. An accidental injury requiring oral surgery; or
 - ii. Oral surgery which involves changing the position of muscle attachments, or removing a tumor, cyst, torus or excess tissue; and
 - b. The event occurs while the patient is covered for these benefits; and
 - c. The work is finished within 12 months after the event.
 - 4. Charges for replacing a dull denture if needed due to a change in the structure of the mouth or due to wear and tear of the denture, if replaced after the later of:
 - a. 5 years after the date the denture is installed; or
 - b. 2 years after the date the patient became covered for these benefits.
 - 5. Charges for repairing a denture or bridge.

CLASS IV - ORTHODONTIC SERVICES

Orthodontic appliances and treatment to correct problems of growth and development (including malocclusion, periodontal disease, temporomandibular dysfunction or combinations of those problems), subject to the following limitations:

- 1. Benefits under this section are only available for covered dependent children under age 26;
- 2. Benefits for active orthodontic treatment are limited to 36 consecutive months of treatment and benefits for retention treatment are limited to 18 consecutive months of treatment;
- 3. Benefits will not be provided for the replacement or repair of any appliance used during orthodontic treatment;
- 4. Upon completion of an orthodontic treatment, no further orthodontic benefits will be available until 5 years have elapsed; and
- 5. Benefits under this section are limited to \$1,000 per person per lifetime.

DENTAL EXCLUSIONS

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

Dental services not ordered by a physician.

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

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

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

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

The following items:

1. myofunctional therapy
2. athletic mouthguards
3. implants
4. oral hygiene, dietary, plaque control and other educational programs
5. duplicate prosthetic appliances
6. porcelain veneered crowns or pontics placed on or in place of a tooth behind the second bicuspid, to the extent the charges would be more than the charges that would have been a covered dental charge for acrylic veneered crowns or onlays
7. gold inlays or onlays

Services and supplies not specifically mentioned in the Plan.

VISION BENEFITS

Routine eye examinations, glasses and contact lenses up to the maximums stated in the Schedule of Benefits.

HEALTH PLAN EXCLUSIONS AND LIMITATIONS

The following charges are not covered under this Plan:

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

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

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

Any treatment for sickness or injury for which the covered person is required to be covered (or is actually covered) under any workers' compensation law, employees' liability law, or similar law and for which the covered person is entitled to benefits with respect to such sickness or injury under such law.

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

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

Treatment, services or surgery for weight control, whether or not prescribed by a Physician or associated with an illness or in any part of the treatment plan for another sickness except as specifically required by the Patient Protection and Affordable Care Act.

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

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

Services for Temporomandibular Joint Syndrome.

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

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

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

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

Charges incurred for hearing aids, batteries, or repairs; except as specifically provided herein.

The diagnosis or treatment of infertility or restoration or enhancement of fertility, including, but not limited to, therapeutic injections, fertility and other drugs, surgery, artificial insemination, in-vitro fertilization, or surgical reversal of elective sterilization.

Charges for treatments that are Experimental and/or Investigational.

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

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

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

Charges incurred for vitamins (other than prenatal), nutritional supplements and treatment of a nicotine habit except as stated herein. **Birth control pills and certain similar birth control products are covered through the Retail Drug Plan. All other means of prescribed birth control prevention, including but not limited to injections and Norplant implants, will be payable under the Major Medical Plan.**

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

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

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

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

Maternity services in relation to a surrogate mother.

Charges incurred for chelation therapy.

Biomicroscopy, field charting or aniseikonia investigation.

Orthopic or visual training.

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

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

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

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

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

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

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

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

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

Services and supplies not specifically mentioned in the Plan.

DEFINITIONS

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

ACADEMIC YEAR

An Academic Year commences on the first day of regular student attendance in the Fall and ends on the last day of regular student attendance in the Spring or early Summer as determined by each individual employer.

ACTIVE EMPLOYEE

An active employee is an employee who performs all of the duties of his job with the employer on a permanent full-time basis and who has begun work for the employer. To be full-time, an active employee must be scheduled to work for the employer at least 30 hours (or more) per week and on the regular payroll of the employer. An active employee shall also include a full-time employee as defined by 26 USC §4980H(c)(4) during the stability period applicable to such employee.

ADVERSE BENEFIT DETERMINATION

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

ALTERNATE RECIPIENT

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

AMBULATORY SURGICAL CENTER

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

APPROVED LEAVE OF ABSENCE

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

CALENDAR YEAR

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

CLAIM

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

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985.

COSMETIC SURGERY

Surgery that is intended to:

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

COVERED PERSON

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

CUSTODIAL CARE

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

DEPENDENT

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

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

1. Is a legal resident of the same country in which the employee resides;
2. Is a natural child, legally adopted child, foster child, or child that has been placed for adoption (such covered person must have assumed legal obligation for total or partial support of such child in anticipation of adoption). The child's placement for adoption with such covered person terminates upon the termination of such legal obligation. After such legal adoption, the child is considered to be an adopted child. A child is also a covered person's stepchild, or is a child that the covered person is required by a Qualified Medical Child Support Order to cover under the Plan, or a child for which the covered person has been granted legal custody or guardianship, and where required by applicable state law, any child of an unmarried minor female dependent of the employee. Notwithstanding any provision herein to the contrary, grandchildren are not considered eligible dependents under this Plan.
3. Is less than 26 years old; or less than 30 years old if an unmarried United States military veteran who (i) is an Illinois resident, (ii) has received a release or discharge other than a dishonorable discharge, and (iii) submits to the TPA a copy of a properly completed form DD 214 "Certificate of Release or Discharge from Active Duty."

Unmarried children who are incapable of self-sustaining employment by reason of mental retardation or physical handicap will be eligible for coverage under the Plan provided such incapable child became incapable prior to attainment of the termination age stated herein. An incapacitated child must be

primarily financially dependent upon the primary covered person for support and maintenance. Such child may continue coverage past the terminating age stated above, provided the employee's coverage remains effective.

ELIGIBILITY DATE

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

ELIGIBLE PARTICIPANT

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

EMERGENCY

Emergency means a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

EMERGENCY SERVICES

Emergency Services means, with respect to an Emergency, the following:

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.
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 to stabilize the patient.

ENROLLMENT DATE

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

EXPERIMENTAL and/or INVESTIGATIONAL

Means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered. The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

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 the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

This Plan shall comply with 42 USC 300gg-8.

EXPENSES INCURRED

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

EXTENDED CARE/SKILLED NURSING FACILITY

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

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

FAMILY MEMBER

A primary covered person or his dependent(s).

FULL TIME EMPLOYEE

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

HEALTH CARE PROFESSIONAL

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

HIPAA

The Health Insurance Portability and Accountability Act of 1996.

HOME HEALTH CARE AGENCY

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

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

The term "Home Health Care" shall consist of:

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

HOSPICE CARE

Palliative care and management of a covered person whose life expectancy is 6 months or less. Hospice care may be provided through either:

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

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

HOSPICE TEAM

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

HOSPITAL

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

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

INJURY

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

LATE ENROLLEE

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

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

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

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

MARRIAGE

Is either (i) a legal marriage as defined by applicable state law, or (ii) a legal relationship between 2 persons, of either the same or opposite sex, established or recognized as such by the Illinois Religious Freedom Protection and Civil Union Act.

MEDICAL NECESSITY

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

NAMED FIDUCIARY

The person who has the authority to control and manage the operation and administration of the Plan. The Named Fiduciary for the Plan is the Plan Administrator.

NECESSARY SERVICE OR SUPPLY

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

NOTICE OR NOTIFICATION

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

OUTPATIENT

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

PHYSICAL HANDICAP

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

PHYSICIAN

A practitioner of the healing arts who is duly licensed in the state where he is practicing and who is treating within the scope and limitation of that license.

PHYSICIAN SERVICES VISIT

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

PLACEMENT FOR ADOPTION

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

PLAN SPONSOR

The Western Area School Association. The Plan Sponsor is also the Plan Administrator, or Administrator.

PRACTITIONER

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

PREVENTIVE HEALTH SERVICES are:

1. Evidence based items or preventive services that have an "A" or "B" rating from the United States Preventive Services Task Force;
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Evidence-informed preventive care services and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents;
4. Additional Preventive care and screenings not described above as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for women; and
5. The current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention, other than those issued in or around November 2009.

An item, service, or screening shall only be considered a Preventive Health Service during the time the Affordable Care Act requires the item, service, or screening to be covered by the Plan.

PREVENTATIVE PHYSICAL THERAPY

Physical therapy that is prescribed by a physician for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.

PRIMARY CARE PHYSICIAN

A physician with a primary medical practice concentrating in general practice, family practice, pediatrics, obstetrics/gynecology, or internal medicine.

PRIMARY COVERED PERSON

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

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

REASONABLE AND CUSTOMARY

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

1. Using current publicly-available data reflecting fees typically reimbursed to providers for professional services, adjusted for geographical differences;
2. Using current publicly-available data reflecting the costs for facilities providing the same or similar services, adjusted for geographical differences plus a margin factor; or
3. Using an amount negotiated with the provider for the specific services provided.
4. For emergency department treatment, the reasonable and customary amount with respect to a Non-PPO Provider shall mean the greater of:
 - a. The amount calculated using the above methodology;
 - b. The median rate negotiated with PPO Providers; or
 - c. The fee paid by Medicare for the same services.

REGISTERED PROFESSIONAL NURSE

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

RELEVANT DOCUMENT

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

the denied treatment opinion or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

SEMI-PRIVATE

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

SICKNESS

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

SPECIALITY PHYSICIAN

A physician who is not a primary care physician.

SPEECH THERAPIST/SPEECH THERAPY AGENCY

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

SPOUSE

Is a party to a marriage.

THIRD PARTY ADMINISTRATOR

The firm providing administrative services to the Plan Sponsor in connection with the operation of the Plan. The Third Party Administrator performs certain functions, at the direction of the Plan Sponsor, including enrollment applications, maintaining current Plan data, billing, processing and payment of covered benefits, and providing the Plan Sponsor with any other information deemed necessary by the Plan Sponsor.

URGENT CARE FACILITY

A facility designated to primarily treat patients with a medical condition that requires immediate care but is not serious enough to warrant a visit to a hospital emergency room. An Urgent Care Facility may be a separate unit of a hospital or a standalone facility.

ELIGIBILITY

ELIGIBLE EMPLOYEE

An employee who is directly employed in the regular business of and compensated for services by the employer and regularly works full-time. An employee is considered to be working full-time if he works at least 30 hours per week (or less if absent from work due to sickness, injury or approved leave of absence), excluding vacations and holidays, and who is on the permanent payroll of the employer. An employee is also considered to be working full-time if he is a full-time employee as defined by 26 USC 4980H(c)(4) during the stability period applicable to such employee. When this Plan acquires new school districts that previously provided group health coverage to retirees of such plan, coverage for retirees currently covered under such plan at the time the school district was acquired by this Plan, will remain covered on the same basis as an active employee, or in the case of an IMRF employee, on the same basis as an IMRF employee. Otherwise, retiree coverage is not available under this Plan.

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

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

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

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

ELIGIBLE COBRA PARTICIPANT

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

ELIGIBLE IMRF PARTICIPANT

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

ELIGIBLE DEPENDENT

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

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

1. A natural child of the employee;
2. A step-child of the employee;
3. A child that the employee is required by a Qualified Medical Child Support Order to cover under the Plan;
4. A child who the employee has been granted legal custody or guardianship;
5. Where required by applicable state law, any child of an unmarried minor female dependent of the employee.

Provided a child is one as listed on the prior page, such child must be under age 26; or less than 30 years old if an unmarried United States military veteran who (i) is an Illinois resident, (ii) has received a release

or discharge other than a dishonorable discharge, and (iii) submits to the TPA a copy of a properly completed form DD 214 "Certificate of Release or Discharge from Active Duty."

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

If other dependent medical coverage already exists on the day a newborn is born, coverage for such newborn child will become effective on the date of birth; however, no claims will be processed until the appropriate paperwork has been filed with the Plan Sponsor. If other dependent medical coverage does not exist on the day the newborn is born, the appropriate paperwork must be filed within 31 days following birth in order for coverage to be effective on the date of birth. If both parents of a child are employees of the Plan Sponsor and covered for benefits, either, but not both, may cover the child as a dependent.

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

SPECIAL ENROLLMENT PERIODS

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

1. The employee or dependent was covered under a group health plan at the time coverage was previously offered to the employee or dependent.
2. The employee or dependent's coverage was:
 - a. under a COBRA continuation provision and the coverage was exhausted; or
 - b. not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of marriage, legal separation, divorce, death, termination of employment (whether voluntary or involuntary), reduction in the number of hours of employment (whether voluntary or involuntary)), or employer contributions toward such coverage were terminated.
3. Under the terms of this Plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in paragraph 3 above.
4. The employee or dependent has exceeded his lifetime maximum benefit on all benefits under another benefit plan. The request for Special Enrollment must be made within 30 days after the date the benefit maximum has been reached.

In addition to 1 through 4 above, if an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, such employee will be able to enroll himself or herself. If there are other eligible dependents, they can also be enrolled. Requests for enrollment must be made within 31 days after the marriage, birth, adoption or placement for adoption. Coverage through this special enrollment period is to be retroactive to the date of marriage, birth, adoption or placement for adoption.

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

Dependents

If the individual is a primary covered person under the Plan (or has met any waiting period applicable to becoming a primary covered person under the Plan and is eligible to be enrolled under the Plan but for a failure to enroll during a previous enrollment period), AND if a person becomes such a dependent of the

individual through marriage, birth, or adoption or placement for adoption, the Plan shall provide for a dependent special enrollment period during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the Plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

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

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

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

1. In the case of marriage, as of the date of the marriage;
2. In the case of a dependent's birth, as of the date of such birth; or
3. In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

MEDICAID AND CHIP SPECIAL ENROLLMENT PERIOD

The Plan shall also permit an employee or dependent who is eligible, but not enrolled, for coverage under the terms of the Plan to enroll for coverage during the 60 day period immediately following one of the events described below:

1. The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the employee or dependent under such plan is terminated as a result of loss of eligibility for such coverage; or
2. The employee or dependent becomes eligible for assistance, with respect to coverage under the Plan, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

The coverage of an employee or dependent enrolling pursuant to a Medicaid and CHIP special enrollment period shall become effective on the date of the event described in 1 or 2 above.

SELECTION OF DEDUCTIBLE OPTION SUBPLAN

Families of special enrollees who are covered by the Plan at the time of special enrollment will also have the opportunity to choose to change deductible option subplans, including moving to the Health Savings Account Option, at the time of the special enrollment of a family member.

INTERNAL PROMOTIONS

The Plan shall also permit a promoted employee who is enrolled in the Plan to enroll any dependents who are eligible, but not enrolled, for coverage under the terms of the Plan during the 30 day period immediately following the date such employee becomes a promoted employee. A promoted employee means an employee who is promoted internally to a position that requires an administrative certificate. The coverage for any dependent enrolling pursuant to this provision shall be effective on the date the employee's promotion takes effect with the employer.

OPEN ENROLLMENT FOR LATE ENTRANT

Late entrants may enroll for coverage under this Plan during the open enrollment period. The open enrollment period is from August 15th through September 15th with any resultant change in coverage becoming effective on October 1st of the same year. If an employee does not submit a formal written application for coverage under this Plan during the open enrollment period stated, such employee will not be able to enroll until the next annual open enrollment period unless the employee qualifies under this Plan's "Special Enrollment Periods" provision. Notwithstanding the foregoing, there will be an additional open enrollment period from January 1, 2018, to January 15, 2018, with any resultant change in coverage to become effective February 1, 2018.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan will comply with a Qualified Medical Child Support Order creating or recognizing the existence of an alternate recipient's rights to receive benefits for which a covered person is eligible under this Plan.

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

1. The name and last known mailing address of the covered person and the name and last known mailing address of each alternate recipient.
2. A reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined.
3. The period for which the Order applies.
4. Each Plan to which the Order applies.

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

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

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

EFFECTIVE DATES

EMPLOYEE EFFECTIVE DATE - NON-CONTRIBUTORY COVERAGE

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

EMPLOYEE EFFECTIVE DATE - CONTRIBUTORY COVERAGE

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

1. The eligibility date, provided written application is made on or before the eligibility date.
2. If application for coverage is made within 31 days following eligibility, the effective date will be the date of eligibility.
3. If application for coverage is made more than 31 days after the initial eligibility date for any reason other than one stated in the Special Enrollment Period provision in the Eligibility section, the individual enrolling for coverage will be considered a late entrant (please refer to the Open Enrollment for Late Entrant provision). The individual will be eligible to re-enroll for coverage only during the open enrollment period stated herein, if any, with any resultant change in coverage becoming effective on the date stated in the open enrollment provision of this document.

DEPENDENT EFFECTIVE DATE - NON-CONTRIBUTORY COVERAGE

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

DEPENDENT EFFECTIVE DATE - CONTRIBUTORY COVERAGE

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

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

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

DEPENDENT BENEFITS

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

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

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

TERMINATION DATES

EMPLOYEE BENEFITS

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

1. The later of the:
 - a. Date of termination of the employee's employment,
 - b. Date the employer is first allowed to terminate medical coverage under the applicable collective bargaining agreement covering the employee coincident with or next following the employee's termination of employment, or
 - c. Date the employer by policy or practice authorized by the applicable school board terminates availability for medical coverage following the termination of the employee's employment, but in no event later than the first scheduled day of the next following Academic Year of the employer;
2. The later of the:
 - a. Date employee ceases to be in a class of employees eligible for coverage,
 - b. Date the employer is first allowed to terminate medical coverage under the applicable collective bargaining agreement covering the employee coincident with or next following the date the employee ceases to be in a class eligible for coverage, or
 - c. Date the employer by policy or practice authorized by the applicable school board terminates availability for medical coverage following the date the employee ceases to be in a class of employees eligible for coverage, but in no event later than the first scheduled day of the next following Academic Year of the employer;
3. Date beginning the period for which the employee fails to make any required contribution for coverage;
4. Date the Plan is terminated; or
5. Date the employee dies.

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

For purposes of the COBRA provisions of the Plan, a qualifying event for a covered person with respect to an employee's termination of employment shall be the later of the events set forth in subsections 1(a.), 1(b.), or 1(c.) above and a qualifying event for a covered person with respect to a reduction in hours of employment shall be the later of the events set forth in subsections 2(a.), 2(b.), or 2(c.) above. The qualifying events in all other cases shall be set for elsewhere in the Plan.

DEPENDENT TERMINATION DATE

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

1. Date of termination of employee's coverage;
2. Date employee ceases to be in a class of employees eligible for coverage;
3. Date beginning the period that the employee fails to make any required contribution for coverage;
4. Date the Plan is terminated;

5. The first of the month next following the day the employee dies; or
6. Date dependent loses his eligible status, as defined herein.

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

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

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

1. Coverage shall cease for a covered employee (and his dependents) for the duration of the leave if at any time the covered employee is more than 30 days late in paying any required contribution.
2. A covered employee who declines coverage during the leave or whose coverage is terminated as a result of his failure to pay any required contributions shall, upon return from the leave, be entitled to be reinstated to the Plan on the same terms as prior to taking the leave, without any qualifying period or physical examination.
3. With respect to an FMLA leave, if a covered employee who is a key employee does not return from leave when notified by the employer that substantial or grievous economic injury will result from his reinstatement, the key employee's entitlement to Plan benefits continues unless and until the covered employee advises the employer that he does not desire restoration to employment at the end of the leave period, or the leave entitlement is exhausted, or reinstatement is actually denied.
4. Any portion of the cost of coverage which had been paid by the covered employee prior to the leave, must continue to be paid by the employee during the leave. If the cost is raised or lowered during the leave, the employee shall pay the new rates. If the leave is unpaid, the employee and the employer shall negotiate a reasonable means for paying the employee's portion of the cost.
5. If the employer provides a new health plan or benefits or changes the health benefits or Plan while the employee is on leave, the covered employee is entitled to the new or changed plan and benefits to the same extent as if the employee were not on leave.
6. With respect to an FMLA leave, the employer may recover its share of the cost of benefits paid during a period of unpaid leave if the employee fails to return to work after the employee's leave entitlement has been exhausted or expires, unless the reason the employee does not return to work is due to (i) the continuation, recurrence, or onset of a serious health condition which would entitle the employee to additional leave under FMLA; or (ii) other circumstances beyond the employee's control. If an employee fails to return to work because of the continuation, recurrence, or onset of a serious health condition, thereby precluding the employer from recovering its share of the cost of benefits paid on the covered employee's behalf during a period of unpaid leave, the employer may require medical certification of the employee's or the dependent's serious health condition. The employee is required to provide medical certification within 30 days from the date of the employer's request. If the employer requests medical certification and the covered employee does not provide such certification in a timely manner, the employer may recover the costs of benefits paid during the period of unpaid leave.
7. With respect to a VESSA leave, the employer may recover its share of the cost of benefits paid during a period of unpaid leave if the employee fails to return to work after the employee's VESSA leave entitlement has been exhausted or expires, unless the reason the covered employee does not return to work is due to (i) the continuation, recurrence, or onset of domestic or sexual violence would

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

8. A FMLA leave and VESSA leave shall run concurrently to the extent permitted by law.

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

INTRODUCTION

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

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

QUALIFIED BENEFICIARIES MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

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

HOW IS COBRA COVERAGE PROVIDED?

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

COBRA continuation coverage is a temporary continuation coverage. When the qualifying event is the death of the employee, entitlement of the employee to Medicare benefits (under Part A, Part B, or both), employee and spouse divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage may last for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee, may last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which employment terminates, COBRA continuation coverage for spouse and children can

last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight (8) months). Otherwise, when the qualifying event is the end of employment or reduction of employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two (2) ways in which this 18-month period of COBRA continuation can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH CONTINUATION COVERAGE

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

EARLY TERMINATION OF COBRA COVERAGE

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

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

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

HOW TO ELECT COBRA COVERAGE

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

coverage on behalf of any dependent children. The employee or the employee's spouse can elect (or decline) continuation coverage on behalf of all the qualified beneficiaries.

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

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

HOW MUCH DOES COBRA CONTINUATION COVERAGE COST?

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

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

WHEN AND HOW MUST PAYMENT BE MADE?

First payment for continuation coverage

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

Periodic payments for continuation coverage

After first payment for continuation coverage is made, qualified beneficiary(ies) will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary will be provided with the Election Form. The periodic payments must be made

on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the date stated on the Election Form for that coverage period. If a periodic payment is made on or before the first day of the coverage period to which it applies, coverage under the Plan will continue for that coverage period without any break. The plan, depending on its procedures, may or may not send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

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

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

QUESTIONS ABOUT CONTINUATION COVERAGE

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

KEEP THE PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

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

NOTE

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

UNIFORMED SERVICES ACT

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), continuation coverage under the Plan is available to Covered Persons under certain specified conditions. Any extension of benefits period provided pursuant to this provision shall not postpone the starting date for measurement of the maximum period available for continuation of benefits pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage Rights Under COBRA provision.

ELECTION AND DURATION OF COVERAGE

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

1. the 24 month period beginning on the date on which the covered employee's military leave began; or
2. the day after the date on which the employee fails to apply for or return to a position of employment with the Employer following the expiration of the leave as set forth in Section 4312(e) of USERRA.

BENEFITS

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

PAYMENT FOR BENEFITS

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

EMPLOYEE RETURNING FROM MILITARY LEAVE

In the case of an employee whose coverage under the Plan was terminated by reason of service in the uniformed services, the employee and his eligible dependents shall again be eligible for coverage under the Plan immediately upon return to active work. In addition, no other Plan limitation or exclusion shall apply to such returning employee and his eligible dependents to the extent that such limitation or exclusion would not have applied had the employee remained on the Plan during the military leave period. However, the preceding sentence shall not apply to the coverage of any Sickness or Injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

CONTINUATION OF COVERAGE UNDER ILLINOIS MUNICIPAL RETIREMENT FUND (IMRF)

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

1. A full-time employee who is removed from an employer's payroll due to retirement or disability, and who immediately becomes entitled to receive an IMRF pension or disability benefit;
2. The dependents of such a retired or disabled Employee which are covered under the Plan on the day before such employee is removed from the employer's payroll; and
3. The surviving spouse of such a retired or disabled employee, but only if the spouse:
 - a. is covered under the Plan on the day before such Employee's death;
 - b. is eligible for IMRF benefits; and
 - c. elects to receive an IMRF surviving spouse pension (rather than a lump sum death benefit).

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

1. The date the retired or disabled employee:
 - a. again becomes an active participant in IMRF;
 - b. is convicted of an IMRF job related felony;
 - c. dies; or
 - d. fails to pay any required contribution for coverage;
2. The date a disabled employee is no longer entitled to IMRF benefit payments or takes a separation refund;
3. The date a spouse or child ceases to be a dependent as defined herein;
4. The date the surviving spouse:
 - a. remarries prior to age 55;
 - b. dies; or
 - c. fails to pay any required contribution for coverage;
5. The date the employer terminates medical coverage for all employees under the Plan; or
6. The date the retired or disabled employee voluntarily terminates coverage, to include any covered dependents.

Coverage for such retirees, disabled employees, and surviving spouses will be the same as for other similarly situated covered persons and will be subject to any benefit changes or cost increases which take effect after the employee is removed from the employer's payroll. The retiree, disabled employee, or surviving spouse will be required to pay 100% of the cost of Plan coverage by each monthly due date. Within 15 days after a full-time employee retires, is removed from the employer's payroll due to disability, or dies, the Plan will:

1. verify the employee's or surviving spouse's eligibility for IMRF benefits; and
2. send the employee a notice of this continuation privilege (including the cost for continued Plan coverage).

For a disabled Employee, this continuation right will apply only if, after reviewing his or her medical information, the IMRF determines that IMRF disability benefits are payable. For a surviving spouse of a disabled employee, this continuation right will apply only if the spouse elects a monthly annuity (rather than a lump sum death benefit).

To continue Plan coverage, the retired or disabled employee must send the Plan written election and first payment within 15 days after receipt of notice by certified mail, return receipt requested. An individual allowed coverage pursuant to this Section cannot enroll in the Plan as (i) a late entrant during the open enrollment period, if any, or (ii) during a special enrollment period.

COORDINATION OF BENEFITS PROVISION

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

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

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

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

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

Dissimilar Plans

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

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

If all these conditions are met, then the Dissimilar Plans criteria has been met. As such, obligations of this Plan to provide benefits for expenses incurred but for which benefits were not paid by the primary plan is limited, and this Plan, the secondary plan, will coordinate coverage as the secondary plan using its own

benefit plan as the primary plan but considering benefits for claim payment purposes, solely as though it is the secondary plan. For the purposes of administering this provision, this Plan will consider benefits as though it is the primary plan; however, this Plan will pay only the difference that is payable as a secondary plan assuming that the secondary plan has identical benefits to this Plan.

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

MEDICARE BENEFITS

The Plan will coordinate benefits with Medicare in accordance with the Medicare secondary payor requirements of federal law.

In spite of the Plan language to the contrary, if a covered person is eligible for Medicare and Medicare would be the primary payor, benefits otherwise payable on behalf of that covered person shall be reduced by the amount of benefits available from Medicare, regardless of whether such benefits are actually received from Medicare.

CLAIMS PROCEDURE

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

Proof of loss must be furnished to the Third Party Administrator, not later than 90 days after the loss. Claims that are not submitted to the Third Party Administrator within the time frame stated will be denied. If it is not reasonably possible to furnish such notice within the time specified, it will not invalidate or reduce the claim payment.

How to File a Claim:

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

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

Following is a description of how the Plan processes claims for benefits. A claim is defined as a rescission of coverage or as any request for a Plan benefit made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the claim. If you have any questions regarding this procedure, please contact the Third Party Administrator.

The definitions of the types of claims are:

Urgent Care Claim

A claim involving Urgent Care is any claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

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

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

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

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

PRE-SERVICE CLAIM

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

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

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

Request to extend course of treatment 15 days

POST-SERVICE CLAIM

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

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

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

NOTICE TO CLAIMANT OF ADVERSE BENEFIT DETERMINATIONS

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

1. The specific reason or reasons for the adverse determination.
2. Reference to the specific Plan provisions on which the determination was based.
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures.
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
6. If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.
7. If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

APPEALS

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

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

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

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

1. was relied upon in making the benefit determination;
2. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
4. constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

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

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

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

The Plan will further ensure that:

1. Any notice of adverse benefit determination or decision on appeal include information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable), and a statement describing the availability as soon as practicable, upon request, of the diagnosis code, and the treatment code and their corresponding meanings. A request for this information will not, in itself, be considered an appeal.
2. In the case of a decision on appeal, the decision shall include a discussion of the decision.
3. The Plan will provide a description of available internal appeals and external review processes, including how to initiate an appeal and the availability of and contact information for any assistance or ombudsman to assist individuals with internal claims and appeals and external review processes.

EXTERNAL APPEALS

When a claimant receives an adverse benefit determination on appeal of a claim that involves medical judgment or a rescission of coverage, the claimant has 4 months after the date of receipt of a notice of the notice of denial of the appeal in which to file a request for an external review of the adverse benefit determination. If there is no corresponding date 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. Claims involving "medical judgment" for this purpose include, but are not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or the Plan's determination that a treatment is experimental or investigational. A claim that does not involve a medical judgment or rescission is not eligible for an external review and the Plan's decision on appeal is final.

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:

1. The claimant is or was covered under the Plan at the time the claim was incurred;
2. 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;
3. The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process applicable law; and
4. The claimant has provided all the information and forms required to process an external review.

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

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

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

1. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
2. The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
3. Within 5 business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.
4. Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Plan.
5. The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - a. The claimant's medical records;
 - b. The attending health care professional's recommendation;
 - c. Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, claimant, or the claimant's treating provider;
 - d. The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
 - e. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - f. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

- g. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
6. The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.
7. The assigned IRO's decision notice will contain:
 - a. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - b. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - c. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - d. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - e. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;
 - f. A statement that judicial review may be available to the claimant; and
 - g. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
8. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years. An IRO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

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

EXPEDITED EXTERNAL APPEALS

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

1. The adverse benefit determination involves an urgent care claim of the claimant for which the timeframe for completion of an expedited internal appeal under the external review procedures would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
2. If the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an

admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

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

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

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

The Plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decisions, in accordance with the requirements applicable to a standard external review above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 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 must provide written confirmation of the decision to the claimant and the Plan.

ACTIONS AT LAW

All claim appeal procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action against the Plan must be commenced within 30 days after the Plan's claim review procedures have been exhausted or are no longer required to be complied with under applicable law.

GENERAL PROVISIONS

ASSIGNMENT OF BENEFITS NOT PERMITTED

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

CLAIM DETERMINATIONS

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

CLAIM PROCEDURES

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

CLERICAL ERROR

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

COMPLIANCE

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

CONTRIBUTIONS

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

DATA REQUIRED

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

DISCRETIONARY AUTHORITY

Final authority for interpretation of the terms and provisions of the Plan is vested in the Plan Sponsor. Any interpretation so required by the Plan Sponsor shall be made in good faith, subject to reasonable care and prudence, and all such interpretations are final. The Plan Sponsor shall have discretionary authority to determine eligibility for benefits and to construe the terms of the Plan.

DISCRIMINATION AGAINST PROVIDERS

Notwithstanding anything in the Plan to the contrary, the Plan shall not discriminate against providers in violation of 42 USC 300gg-5.

FACILITY OF PAYMENT

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

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

LIENS

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

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

MISCELLANEOUS

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

MISSTATEMENTS

If any relevant fact as to an individual to whom the coverage relates is determined to have been intentionally misrepresented or constituted fraud, coverage will be rescinded and an equitable adjustment of contributions will be made.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

TERMINATION OF THE PLAN OR COVERAGE

This Plan shall continue in effect until terminated by the Plan Sponsor pursuant to the terms of this section.

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

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

BENEFITS SUBJECT TO THIS PROVISION

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

PAYMENT CONDITION

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

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 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. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

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

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

SUBROGATION

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

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.

The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

1. The responsible party, its insurer, or any other source on behalf of that party.
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. Workers' compensation or other liability insurance company.
5. 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(s) 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(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

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(s) is fully compensated by his or 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. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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, express written consent of the Plan.

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(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

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(s).

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.

PARTICIPANT IS A TRUSTEE OVER PLAN ASSETS

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he/she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
2. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

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, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
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. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

SEPARATION OF FUNDS

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

WRONGFUL DEATH

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

OBLIGATIONS

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. 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.
2. 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.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
7. 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.
8. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
9. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.

10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

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

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

OFFSET

If timely repayment is not made, or the Participant and/or his or 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(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

MINOR STATUS

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

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

LANGUAGE INTERPRETATION

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

SEVERABILITY

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.

PROTECTED HEALTH INFORMATION

PERMITTED DISCLOSURE OF ENROLLMENT/DISENROLLMENT INFORMATION

The Plan may disclose to the Plan Sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled.

PERMITTED USES AND DISCLOSURE OF SUMMARY HEALTH INFORMATION

The Plan may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending, or terminating the Plan.

“Summary Health Information” means information that (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor had provided health benefits under the Plan; and (b) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

PERMITTED AND REQUIRED USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PLAN ADMINISTRATIVE PURPOSES

Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 1.04 and obtaining written certification pursuant to Section 1.06, the Plan (or an Insurer on behalf of the Plan) may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. “Plan administration purposes” means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

CONDITIONS OF DISCLOSURE FOR PLAN ADMINISTRATION PURPOSES

The Plan Sponsor agrees that with respect to any PHI (other than Enrollment/ Disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan (or an Insurer on behalf of the Plan) the Plan Sponsor shall:

1. Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.
2. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan.
3. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to and complies with the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.
4. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
6. Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524.
7. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526.
8. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.
9. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.
10. 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 information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
11. Ensure that the adequate separation between the Plan and the Plan Sponsor (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

ADEQUATE SEPARATION BETWEEN PLAN AND THE PLAN SPONSOR

The Plan Sponsor shall allow those classes of Plan Sponsor or Employer employees or other persons in the Plan Sponsor's or Employer's control designated by the Plan Sponsor to be given access to PHI. No other persons shall have access to PHI except Plan business associates. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor or the Employer for non-compliance pursuant to the Plan Sponsor's or Employer's employee discipline and termination procedures.

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