CARROLLTON EXEMPTED VILLAGE SCHOOL DISTRICT

HEALTH BENEFIT PLAN

SCHEDULE OF MEDICAL BENEFITS

BENEFITS	PPO	NON-PPO
BASIC EXPENSE BENEFITS	(No deductible applies to Basic Benefits	
Hospital Benefit (Max of 365 days/disability)	90%	70%
Surgical Benefit	90%	70%
In-Hospital Physician Benefit (Max of 365 days per disability)	90%	70%
Second Surgical Opinion Benefit-	90%	70%
Maternity Benefit	Same as any Illness	
Diagnostic X-Ray & Laboratory Benefit	90%	70%
Preventive Services (required under ACA)	100%	Not Covered
Emergency Accident Benefit	90%	
Transplant Benefit	90%	70%
MAJOR MEDICAL BENEFITS		
Calendar Year Deductible Per Covered Person Per Covered Family	 $150 $300	
Benefit Percentage Payable	90%	80%
MAXIMUM OUT-OF-POCKET AMOUNT/CAL YEAR (Basic/Major Medical Combined) – does not include deductible. Per Covered Person Per Covered Family	 $500 $900	 $600 $1,200
RETAIL PRESCRIPTION DRUG BENEFIT Prescription Drug Deductible	80% after Prescription Drug Deductible $50 per person or per family per calendar yea Max out-of-pocket for retail and mail order drugs combined is $5,950/person and $12,000/family/cal year	
MAIL ORDER PRESCRIPTION DRUG BENEFIT Generic Co-Pay Brand Name Co-Pay	100% after Co-Pay per prescription filled or refilled $10 $30 Max out-of-pocket for retail and mail order drugs combined is $5,950/person and $12,000/family/cal year	

PRE-ADMISSION NOTIFICATION IS REQUIRED FOR ALL NON-EMERGENCY HOSPITAL ADMISSIONS. POST-ADMISSION NOTIFICATION IS REQUIRED FOR ALL EMERGENCY HOSPITAL ADMISSIONS. IF NOT RECEIVED, A PENALTY OF $500 WILL BE APPLIED TO THE HOSPITAL CONFINEMENT.

SCHEDULE OF DENTAL BENEFITS

CALENDAR YEAR DEDUCTIBLE	
TYPE I SERVICES	NONE
TYPE II, III & IV (ORTHODONTIC)* SERVICES COMBINED	$25 PER PERSON $50 PER FAMILY
BENEFIT PERCENTAGES	
TYPE I SERVICES	100% OF REASONABLE CHARGE
TYPE II SERVICES	80% OF REASONABLE CHARGE
TYPE III SERVICES	50% OF REASONABLE CHARGE
TYPE IV (ORTHODONTIC)* SERVICES	50% OF REASONABLE CHARGE
MAXIMUM BENEFIT PAYABLE PER CALENDAR YEAR	
TYPE I, II & III SERVICES COMBINED	$1,000
MAXIMUM LIFETIME BENEFIT	
TYPE IV (ORTHODONTIC)* SERVICES	$1,000

* Type IV (Orthodontic) Services are only covered for Covered Persons under age 19, or age 25 for dependent children who are Eligible Dependents.

SCHEDULE OF VISION BENEFITS

The Plan will pay up to the following limits:

VISION EXAMINATION	$75
LENSES and FRAMES	$250
CONTACT LENSES (including contact lens fitting fees)	
NECESSARY	$300
COSMETIC	$150

Time Period of Benefits
Vision examinations are covered once every twelve (12) months. Frames and lenses are limited to one complete set every twenty four (24) month period. The time period will begin on the date on which the last payment of benefits for each item was made under this Plan of Benefits. Benefits for contact lenses are available every twelve (12) months (contact benefits are not available if lens/frame benefit is used).

Contact Lenses
Contact Lenses will be considered as necessary under the following circumstances:
1. If visual acuity is not correctable to 20/70 in the better eye, except by the use of contact lenses; or
2. If the patient is being treated for a condition, such as Keratoconus, or Anisometropia, and contact lenses are customarily used as part of the treatment; or
3. If required following cataract surgery.

* Note: the amount for a single lens is 50% of the amounts shown for a pair of lenses.

PRE-ADMISSION/POST-ADMISSION NOTIFICATION PROGRAM

The Covered Person's ID card will reflect the information for the Pre-Admission/Post-Admission Notification Program.
This Program does not apply to Covered Persons for whom Medicare pays its benefits as primary carrier. If this Program is not followed by the Covered Person, a penalty of $500 will be applied to the Hospital confinement. No penalty will be applied for the failure to notify the Plan for any Hospital stay in connection with childbirth for the mother or newborn child, provided such stay is less than forty-eight (48) hours following a normal vaginal delivery or less than ninety-six (96) hours following a cesarean section.
Instructions for using this program are as follows:

Non-Emergency Hospital Admission. As soon as the Covered Person is told that he needs to be admitted to a Hospital, he must notify the Plan prior to the admission.
Emergency Hospital Admission. If the Covered Person is admitted to the Hospital on an Emergency basis, the Plan must be notified by the next business day following the date of admission. This call can be made by the Covered Person, the Covered Person's Physician, a member of the Covered Person's family, or an authorized Hospital staff member.
Observation. If the Covered Person is in observation status for a period of twenty-four (24) hours or more, it will be treated as an admission for purposes of this provision.

Each Covered Person is responsible for informing the attending Physician of the requirements of the Pre-Admission/Post-Admission procedures. A Partial Confinement will also be subject to the terms of this Program. The Pre-Admission/Post-Admission Notification Program does not guarantee benefits. All benefits are subject to the terms of this Plan. The Pre-Admission/Post-Admission Notification Program applies to each Hospital admission, and if a patient is transferred from one Hospital to another Hospital, the same procedures will need to be followed for each Hospital confinement. If the patient is unconscious or unable to follow the requirements of this Program due to Illness or Injury rendering the patient physically or mentally incapable, the penalty will be waived until the patient is able to follow the terms of the Program.

CASE MANAGEMENT

Case management coordinates care between the Covered Person and Physicians, facilities, and other providers. Case management will be instituted by the Plan when the Plan determines that it would be appropriate (based on diagnosis, procedures, and/or ongoing treatment). If case management is implemented, each Covered Person is required to participate in it and to fully cooperate with the case manager. When case management is instituted, the case manager will obtain information from the Physician(s), discharge planner(s), social worker(s), and/or other providers of health care services and supplies. The case manager will attempt to identify options that will preserve the Covered Person's benefits. Case management options will be communicated to the Covered Person, Eligible Employee, family member(s), and/or Physician(s). The Covered Person, the Covered Person's legal guardian, if any, or the Eligible Employee always has the option to pursue the treatment program of choice; however, the case manager will identify which treatment programs will be covered under the Plan.

PREFERRED PROVIDER PLAN

For purposes of this Plan, the term "PPO Provider" means a Physician, Hospital or other provider that has an agreement with the PPO to provide supplies or services at negotiated rates. The PPO information will be shown on the medical ID card.
The payment rates vary between PPO Providers and non-PPO Providers. The Plan will allow the amount that is negotiated between the PPO and its PPO Providers. If there is a per diem rate that is negotiated between the PPO and a PPO Provider, the per diem amount will be allowed as the eligible expense.
To determine which providers belong to the PPO, Covered Persons can access the PPO's website. The website address is shown on the medical ID card.
In the event that a Covered Person requires Emergency Care, the PPO level of benefits will apply to such charges, even if rendered by non-PPO Providers.
If a Covered Person uses a Hospital that is a PPO Provider for a given procedure, any emergency room Physician, assistant surgeon, anesthesiologist, radiologist, and pathologist charges in connection with that procedure will be payable at the PPO level of benefits, even if rendered by non-PPO Providers.
If a Covered Person is traveling or living outside of the PPO area and incurs medical expenses, such expenses will be payable at the PPO level of benefits.
If services are not available from a PPO provider (as verified by the PPO), the Plan will allow the PPO benefit for a non-PPO provider for those services. Referrals by PPO providers to non-PPO providers will also be paid at the PPO level.

BASIC EXPENSE BENEFITS

Hospital Benefit
Pre-Admission Notification is required for all non-emergency Hospital admissions. Post-Admission Notification is required for all emergency Hospital admissions. **If this program is not followed, a penalty of $500 will be applied to the Hospital confinement.**
The Hospital Benefit begins on the first day of Hospital confinement and pays for Hospital room and board charges for up to the maximum confinement period specified in the Schedule of Medical Benefits. This benefit covers room and board and miscellaneous

expenses. This Semi-Private Room Rate limit does not apply to charges for intensive care and coronary care units. In addition, charges that are in excess of the Semi-Private Room Rate will be covered in full if the Physician certifies that the patient should be in isolation. Two (2) days of Partial Confinement in a Hospital will be considered as one (1) day of confinement. This benefit does not include take-home drugs or other supplies not consumed in the Hospital. Charges incurred in an Alcoholism/Drug Addiction Treatment Facility are included in this benefit. Charges made by a Hospital for Outpatient surgery are included in this benefit. If a Covered Person is discharged from the Hospital and then readmitted within the next ninety (90) days, the second Hospital stay will be counted as a continuation of the first stay.

Surgical Benefit

The Surgical Benefit provides payment for surgical services required for the treatment of Illness or Injury, including charges for a man's elective sterilization (charges for a woman's sterilization will be payable under the Preventive Services Benefit). This benefit will include charges provided by an anesthesiologist or licensed nurse anesthetist. It will also include charges of an Ambulatory Surgical Center, charges for anesthesia and its administration and professional fees directly related to the Outpatient surgery. Services of an assistant surgeon are covered if they are allowable under Medicare RBRVS. The allowable amount for an assistant surgeon will be 20% of the allowance for the primary surgeon, and Medicare RBRVS will be used to determine allowable amounts for (1) multiple surgeries performed on the same day or at the same session; (2) bilateral surgeries; (3) co-surgery and team surgery; and (4) services rendered by a Physician's Assistant.

When a Covered Person is receiving benefits in connection with a mastectomy and elects breast reconstruction in connection with such mastectomy, charges for reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and such Covered Person, are also covered under this benefit.

In-Hospital Physician Benefit

A benefit is payable for professional care rendered by a Physician while the Covered Person is confined in a Hospital for up to the maximum benefit period specified in the Schedule of Medical Benefits. Benefits will only be payable for one (1) Physician's visit per day of confinement. This benefit also covers charges for consultations requested by the attending Physician (for no more than one consultation per admission).

Second Surgical Opinion Benefit

If a Physician has recommended that a surgical operation be performed for a Covered Person, the Plan will pay a benefit for the Covered Person to consult with another Physician for a second opinion. This benefit also includes charges for diagnostic x-ray and laboratory tests performed in connection with the second opinion. The Physician who is being consulted shall be a board certified surgeon in the appropriate specialty, shall not be affiliated in any way with the Physician who will be performing the actual surgery, and shall not assist with the surgery. If the second opinion obtained does not concur with the first Physician's opinion, a third opinion can be obtained and will be payable under this benefit. The third Physician must not be affiliated in any way with the consulting Physicians, or with the Physician who will be performing the actual surgery, and he shall not assist with the surgery. If a second surgical opinion is received, the Covered Person should submit a completed Second Surgical Opinion Benefit Claim Form to Self-Funded Plans, Inc.

Maternity Benefit

The Maternity Benefit includes charges for obstetrical services, prenatal and postnatal care. This benefit also covers an elective abortion. Any services provided by a Nurse-Midwife acting within the scope of a license which allows for providing such services will be payable on the same basis as services provided by a Physician. Charges incurred in a Freestanding Birthing Facility will be payable as if they had been incurred in a Hospital. If the Eligible Employee has dependent coverage, this benefit covers Hospital and Physician charges for the infant with an Illness (well care charges, including circumcision, are covered under the Preventive Services Benefit).

Diagnostic X-Ray and Laboratory Benefit

A benefit is payable for x-ray and laboratory services required in the diagnosis of a condition due to Illness or Injury. Diagnostic x-ray and laboratory expenses related to chiropractic treatment are only payable under the Major Medical Expense Benefits.

Preventive Services Benefit

The Preventive Services Benefit includes preventive care services which are required under the Affordable Care Act. A description of covered services can be found on healthcare.gov under the prevention category.

Emergency Accident Benefit

The Emergency Accident Benefit is payable for expenses incurred for the initial examination and treatment of an accidental Injury, provided such treatment is rendered within seventy-two (72) hours following an accidental Injury. If the initial emergency treatment is furnished within seventy-two (72) hours of the Injury, benefits will also be payable for follow-up treatment furnished within thirty (30) days of the initial treatment.

Transplant Benefit

The Transplant Benefit covers charges for services and supplies furnished in connection with human tissue and organ transplant procedures (kidney, bone marrow, heart, heart-lung, liver, pancreas and cornea) on the same as any other Illness subject to the following conditions:

1. A second surgical opinion must be obtained prior to undergoing any transplant procedure. The mandatory second opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The second opinion must be rendered by a board-certified surgeon who is not affiliated in any way with the Physician or the surgeon who rendered the first surgical opinion. The surgeon who gives the second surgical opinion may not perform the surgery.
2. If the donor is a Covered Person under this Plan, his eligible expenses will be covered if donor benefits are not provided under the recipient's plan.

3. If the recipient is covered under this Plan, eligible medical expenses incurred by the recipient will be considered for benefits. Expenses incurred by the donor, who is not ordinarily covered under this Plan according to participant eligibility requirements, will be considered eligible expenses to the extent that such expenses are not payable by the donor's plan. The donor's charges will be payable as if they had been incurred by the Covered Person.
4. If both the donor and recipient are covered under this Plan, eligible medical expenses incurred by each person will be treated separately for each person.
5. The Reasonable and Customary cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, will be considered an eligible expense under the Major Medical Expense Benefits.

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

A Special Transplant Benefit may be available when a Covered Person participates in the Special Transplant Program. The Special Transplant Benefit provides enhanced transplant benefits and participation in the Program is voluntary. The Special Transplant Benefit provides the following benefits in addition to any transplant benefits available under this plan:

1. Access to Centers of Excellence Transplant Facilities (as defined by the Plan) throughout the United States;
2. Reimbursement, up to a total of $5,000, for approved expenses incurred by the Covered Person and one companion, or both parents if Covered Person is a minor child:
   a. for travel to and from the Centers of Excellence facility when that travel is related to the actual transplant occurrence; and
   b. for lodging expenses related to such travel and occurring prior to and following the actual transplant occurrence; and
3. Waiver of the Covered Person's deductible and co-payments up to $1,500 during the year in which the transplant occurs.

BENEFIT PERCENTAGE PAYABLE/OUT-OF-POCKET AMOUNT
Applies to both Basic and Major Medical Benefits

The Eligible Expenses are payable at the percentages shown each calendar year until the Out-of-Pocket Amount shown in the Schedule of Medical Benefits is reached. Then Eligible Expenses will be payable at 100%. The Out-of-Pocket Amount includes the coinsurance incurred by a Covered Person in a calendar year. The Out-of-Pocket Amount does not include charges applied to the deductible, charges for penalties for failure to comply with the Pre-Admission/Post-Admission Notification Program or Second Surgical Opinion requirements, or charges that are excluded or that exceed limits outlined in this Plan.

MAJOR MEDICAL BENEFITS

Deductible

The deductible is the amount of covered medical expenses which each Covered Person must pay before benefits are provided under these provisions. The deductible amount is specified in the Schedule of Medical Benefits. The deductible applies only once during any calendar year, even though a person may have several different accidents or Illnesses.

Family Deductible

The deductible applies to each person separately, but if the members of a family have incurred deductible charges in excess of the family deductible amount specified in the Schedule of Medical Benefits, no further deductible will be required for any other member of the family for the balance of that calendar year.

Three-Month Carryover Deductible

Any medical expenses incurred during the last three (3) months of a calendar year which apply toward the deductible for that year will also be applied toward the deductible for the next calendar year.

Common Accident Deductible

If two (2) or more members of a family are injured in the same accident, only one (1) deductible will be applied to expenses incurred in that calendar year for Injuries sustained in that common accident.

Eligible Expenses under Major Medical Benefits

The following services and supplies are eligible expenses under the Major Medical Benefits:

1. Hospital charges (at the Semi-Private Room Rate) for room and board and miscellaneous expenses. This Semi-Private Room Rate limit does not apply to charges for intensive care and coronary care units. In addition, charges that are in excess of the Semi-Private Room Rate will be covered in full if the Physician certifies that the patient should be in isolation. Two (2) days of Partial Confinement in a Hospital will be considered as one (1) day of confinement. Charges incurred in an Alcoholism/Drug Addiction Treatment Facility are included in this benefit.
2. Physicians' charges for treatment of an Illness or Injury.
3. Charges for Chiropractic Treatment, to a maximum benefit of $1,500 per calendar year. The term Chiropractic Treatment shall mean the manual manipulation of the spine to restore mobility to the joints and to allow vertebrae to assume their normal position, and other modalities of treatment, including examinations, laboratory services and x-rays provided in connection with such treatment.
4. Charges for the services of a Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.) other than a nurse who ordinarily resides in the Covered Person's home, or is a Close Relative.
5. Charges for anesthesia and the administration thereof.
6. Charges for oxygen and the administration thereof.
7. Charges for chemotherapy and x-ray, radium and radioactive isotope therapy.
8. Charges for blood and blood plasma, to the extent it is not donated or otherwise replaced.
9. Charges for medical appliances, crutches, dressings, and other equipment.

10. Charges for orthopedic braces (except corrective shoes) and prosthetic appliances. Replacements are not covered except in the case of dependent children when the Physician certifies that such replacement is necessary, or if otherwise deemed Medically Necessary.
11. Charges for the rental of Durable Medical Equipment under a lease acceptable to the Plan. The Plan may, in its discretion, authorize purchase of such equipment.
12. Charges by a licensed pharmacist or Physician for such drugs and medicines which can be purchased only upon a Physician's prescription (other than those drugs that are excluded herein and other than those drugs that are covered under the Retail Prescription Drug Benefit or the Mail Order Prescription Drug Benefit).
13. Charges for a Physician's or speech therapist's fees for restoratory or rehabilitory speech therapy for speech loss or impairment due to an Illness or Injury, other than a functional nervous disorder, or due to surgery performed on account of an Illness or Injury. If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.
14. Charges for physical therapy prescribed by the attending Physician as to type and duration when performed by a licensed physical therapist.
15. Charges for professional ambulance service when used in emergency situations to transport a Covered Person from the place of accidental Injury or acute medical episode to the nearest Hospital where required treatment is given. Ambulance charges incurred to transport a Covered Person from one Hospital to another Hospital will be covered only if the first Hospital is not equipped to treat the Covered Person's medical condition. Ambulance charges will only be covered if the attending Physician certifies that such transportation is Medically Necessary. No other charges for transportation or travel will be covered.
16. Charges for home care visits rendered through a Home Health Care Agency. This care is covered if the Physician certifies the medical necessity of home health care. The allowed home care services are the usual and customary services of the Home Health Care Agency which are not specifically excluded hereunder and services provided on an Outpatient basis in a Hospital when such services cannot readily be made available at the Covered Person's place of residence. This benefit covers a maximum of 120 home care visits per calendar year. For the purposes of determining the visits limitation, a visit is a personal contact in the Covered Person's home made for the purpose of providing a covered service by a health worker on the staff of a home care agency or by others under contract or arrangements made with such agency. However, if a service lasts more than four (4) consecutive hours, each four (4) hour segment or part of a segment will be counted as one (1) visit. The following services and supplies are covered: part-time or intermittent nursing care and initial evaluation; physical, occupational and speech therapy; medical social services; part-time or intermittent services of home health aides; dietary guidance; medical services and supplies necessary for the treatment of a condition for which the home health care service is required; the use of medical appliances; and services provided on an ambulatory care basis when such services cannot readily be made available in the Covered Person's home. Notwithstanding anything to the contrary herein set forth, home care services do not include: meals; professional medical services billed for by a Physician; Custodial Care; services of housekeepers; prescription and non-prescription drugs and biologicals; and services of a Close Relative or members of the Covered Person's household.
17. Charges for care rendered by a Hospice. Covered charges include room and board charged by the Hospice; miscellaneous services and supplies; part-time nursing care by or under the supervision of a registered graduate nurse; home health care services; and counseling services by a licensed social worker or a licensed pastoral counselor for the patient and the patient's Close Relatives. Such care is only covered if a Physician has certified that the patient is terminally ill and the patient's life expectancy is six (6) months or less.
18. Charges for care rendered in an Urgent Care Facility.
19. Charges for peritoneal dialysis, renal dialysis or other dialysis procedures performed at the Covered Person's home or on an Inpatient or Outpatient basis in a Hospital or Freestanding Dialysis Facility.
20. Charges for Interferon.
21. Charges for care in a Convalescent Facility if a Physician determines that the Covered Person requires skilled nursing care. In order for this benefit to be payable, the Covered Person must be confined in a Convalescent Facility within fourteen (14) days following a Hospital confinement that lasted at least three (3) days. Charges for room and board (at the Semi-Private Room Rate) and necessary services and supplies will be covered for up to a maximum period of sixty (60) days per calendar year.
22. Charges for a Hospital Outpatient department cardiac rehabilitation program, limited to a maximum benefit of $1,000 per calendar year. This benefit will only be payable if all of the following conditions have been met:
    a. the person has had myocardial infarction, coronary bypass surgery, stable angina pectoris, angioplasty, or a heart transplant;
    b. the person starts his cardiac rehabilitation program within twelve (12) months after discharge from the Hospital; and
    c. the cardiac rehabilitation program is rendered in the Hospital's Outpatient department or in a Medicare-approved facility for cardiac rehabilitation.
23. Charges for occupational therapy prescribed by the attending Physician as to type and duration when performed by a licensed occupational therapist (however, charges incurred for supplies used in connection with occupational therapy are not covered).
24. Benefits for treatment of mental illness and substance abuse shall be payable on the same basis and at the same benefit percentage as any physical Illness.
25. Charges for Routine Patient Costs for Qualified Individuals to participate in an Approved Clinical Trial. For purposes of this coverage, the following definitions apply:

a Routine Patient Costs include items and services typically provided under the Plan for a participant not enrolled in a clinical trial. However, such items and services do not include (1) the investigational item, device or service itself; (2) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (3) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

b. Qualified Individual is a Covered Person who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other Life-Threatening Condition and either (1) the referring health care professional is a participating provider and has concluded that the Covered Person's participation in the clinical trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

c. Approved Clinical Trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other Life-Threatening Condition and is federally funded through a variety of entities or departments of the federal government; is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration; or is exempt from investigational new drug application requirements.

d. Life-Threatening Condition is a disease or condition likely to result in death unless the disease or condition is interrupted.

RETAIL PRESCRIPTION DRUG BENEFIT

The Retail Prescription Drug Benefit covers Medically Necessary drugs which may be lawfully dispensed only upon the written prescription of a Physician licensed to practice medicine. This benefit will cover up to the greater of a thirty-four (34) day supply or 100 unit doses. This benefit also covers growth hormones, Tretinoin topic (e.g. Retin-A), Tazarotene (e.g. Tazorac) and Adapalene (e.g. Differin) for individuals through the age of 25 years, legend vitamins; diabetic supplies and injectable insulin. The Pharmacy Benefit Manager (PBM) for this benefit is shown on the prescription drug ID card.

The following items are covered at 100%, not subject to any deductible:

1. Smoking cessation products, to a limit of 168 day supply in one year of treatment with Generic Nicotine replacement products (Nicotine patch, gum and lozenges) and a limit of 168 day supply in one year of treatment with Generic Zyban or Chantix. This includes prescription and over-the-counter drugs, but there must be a Physician's prescription and covered drugs must be on the PBM's defined drug list.
2. Folic acid products for females under age 56, to a maximum of 100 units per fill, for Generic Drugs only that are on the PBM's defined drug list.
3. FDA approved contraceptives.
4. Certain immunizations.

If drugs are purchased at a PBM pharmacy and the Covered Person uses his PBM card, he will receive preferred pricing from the pharmacy. If the Covered Person is not in possession of his prescription drug ID card, a prescription drug claim form must be completed by the Covered Person and the pharmacist.

The Employer may choose to administer the prescription drug program on a reimbursement basis, without the use of the PBM. If this is the case, the Eligible Employee will submit drug expenses on a medical claim form and be reimbursed by the Plan for eligible prescription drug expenses at the rate shown in the Schedule of Medical Benefits.

The following charges are excluded under this benefit: anti-obesity agents; infertility drugs, Interferon; anti-wrinkle agents (e.g. Renova), regardless of intended use; immunization agents; blood or blood plasma; minoxidil (e.g. Rogaine) for the treatment of alopecia; cosmetic hair removal products; DESI drugs; fluoride supplements; mineral and nutrient supplements; pigmenting/depigmenting agents; therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use (other than as specified herein); charges for the administration or injection of any drug; drugs labeled "Caution - limited by federal law to investigational use," or Experimental/Investigational drugs, even though a charge is made to the Covered Person; and medication which is to be taken by or administered to a Covered Person, in whole or in part, while he is a patient in a licensed Hospital, rest home, sanitarium, Convalescent Facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

MAIL ORDER PRESCRIPTION DRUG BENEFIT

The Mail Order Prescription Drug Benefit will be administered by the PBM. This benefit covers a ninety (90) day supply of many maintenance medications.

MEDICAL PLAN LIMITATIONS AND EXCLUSIONS

The following charges are limited or excluded under the Plan:

1. Charges which were incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.
2. Charges for services which are not Medically Necessary (except as specified herein) or which have not been recommended by a Physician

3. Charges which are in excess of the Reasonable and Customary Charge.
4. Charges for services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable him to live outside of an institution.
5. Charges for Custodial Care.
6. Charges for personal convenience items including, but not limited to, TV, telephone, guest trays, guest beds and reading material.
7. Charges directly or indirectly related to infertility treatment, including artificial methods of conception (including but not limited to in-vitro or in-vivo fertilization, artificial insemination, embryonic transplant, GIFT or ZIFT) and related tests; fertility drugs; or other infertility treatment.
8. Charges for Preventive/Maintenance Care, routine physical examinations, and immunizations (except as specified herein).
9. Charges incurred in connection with eye refractions, vision therapy, any procedure performed to correct nearsightedness or farsightedness, the purchase or fitting of eyeglasses, contact lenses, hearing aids, or such similar aid devices. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery, nor does it apply to the initial purchase of a hearing aid if the loss of hearing is a result of an accidental Injury or a surgical procedure.
10. Charges for Cosmetic Surgery unless required because of an accidental Injury; because of a congenital malformation of a dependent child; due to replacement of diseased tissue which has been surgically removed; or as specified herein.
11. Charges for treatment of bunions (except by capsular or bone surgery); toe nails (except surgery for ingrown nails); corns; calluses; fallen arches; flat feet; weak feet; chronic foot strain; symptomatic complaints of the feet; purchase of orthopedic shoes; or orthotics that are prescribed to treat a foot condition that is not covered. However, this exclusion will not apply to treatment of skin of the feet or toenails if the patient is diabetic.
12. Charges for any care or treatment of teeth, gums, alveolar process, gingival tissues or temporomandibular joint disturbances (including the prevention or correction of teeth irregularities and malocclusion of the jaw by wire appliances, braces or other mechanical aids) unless such charges are for the professional services of a Physician or oral surgeon in rendering any of the following treatments:
    a. reduction of fractures of the jaw or facial bones;
    b. surgical correction of harelip, cleft palate or protruding mandible;
    c. removal of stones from salivary ducts;
    d. bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues;
    e. freeing of muscle attachments; or
    f. surgical treatment of temporomandibular joint disturbances. :
13. Charges incurred in connection with travel expenses of a Covered Person (other than as specified herein) or a provider.
14. Charges for the reversal of an elective sterilization.
15. Charges for sex transformation and hormones related to such treatment and charges for related psychiatric care.
16. Charges for educational materials or training, including biofeedback training.
17. Charges for marital counseling.
18. Charges for hair replacement, transplant, removal or hair growth stimulants.
19. Charges for enrollment in a health, athletic, or similar club; for any treatment of obesity including diet control or diet supplements, except for surgical treatment of morbid obesity which is determined to be in excess of 70% of standard weight tables.
20. Charges for room and board incurred in connection with a Hospital admittance on Friday, Saturday, or holiday unless significant medical treatment is given on those days; significant medical treatment includes any treatment not normally connected with room, board or general nursing services.
21. Charges incurred in connection with any treatment, therapy, teaching technique or program for remedial education or habilitative or rehabilitative training which is principally intended to overcome, ameliorate or compensate for any learning impairment whatsoever, regardless of whether such impairment is diagnosed as functional or organic.
22. Charges for treatment of conditions related to behavioral problems or mental retardation.
23. Charges for vitamins, minerals or dietary supplements.
24. Charges for treatment arising out of or in the course of any employment or occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Workers' Compensation or occupational disease law, whether or not any coverage for such benefits is actually in force.
25. Charges for care in any Hospital owned or operated by any federal government, with the exception of charges for care in a V.A. Hospital for veterans who have non-service-connected disabilities or for Inpatient care in a military Hospital for military retirees, dependents of retirees and dependents of active military personnel.
26. Charges resulting from any intentionally self-inflicted Injury, unless due to domestic violence or a medical condition, and charges for Illness or Injury caused by or contributed to by engaging in an illegal occupation or by committing or attempting to commit a felony.
27. Charges for any services received as a result of Injury or Illness due to an act of war which has occurred after the effective date of the Covered Person's coverage, or caused during service in the armed forces of any country, or arising out of participation in a riot.
28. Charges incurred which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.
29. Charges for the completion of claim forms, medical reports or certifications required by the Plan.
30. Charges for services rendered by a Physician, nurse or licensed therapist if such Physician, nurse, or licensed therapist is a Close Relative of the Covered Person, or resides in the same household as the Covered Person.
31. Charges for Experimental or Investigational procedures.

32. Charges for Hospital room and board and general nursing care when the Covered Person is admitted primarily for diagnostic study or medical observation and the necessary care can properly be provided on an Outpatient basis.
33. Charges for purchase or rental of supplies of common use such as exercise cycles, air purifiers, air conditioners, water purifiers, hypoallergenic pillows or mattresses, waterbeds, elevators, saunas, steambaths, swimming pools, or blood pressure kits.
34. Charges for prescription drugs (including the prescription drug deductible) that are covered under the Retail or Mail Order Prescription Drug Benefit.

DENTAL EXPENSE BENEFITS

Amount Payable
Benefits are payable for each type of service after the deductible for that type of service (if any) has been satisfied. Benefits are payable at the percentage rate applicable to the type of service. Both the deductible and percentage rates applicable for each type of service are specified in the Schedule of Dental Benefits.

Deductible
The deductible is the amount of covered dental expenses which must first be paid by the Covered Person before benefits for Type II, III and IV Services are payable. The deductible applies only once each calendar year.

Family Deductible
If, in any calendar year, the members of a family incur charges toward their deductible equal to the family deductible amount specified in the Schedule of Dental Benefits, no further deductible is required in connection with any other family member for the balance of that calendar year.

Three-Month Carryover Deductible
Any dental expenses incurred during the last three (3) months of a calendar year which apply toward the deductible for that year will also be applied toward the deductible for the next calendar year.

Maximum Benefit
The maximum benefit payable for each person in any calendar year for Type I, II, and III Services combined is specified in the Schedule of Dental Benefits. The maximum lifetime benefit payable for each person for Type IV Services is specified in the Schedule of Dental Benefits.

Pre-Determination of Benefits
Each Covered Person can take advantage of a Pre-Determination of Benefits. Under this provision, the Covered Person files with Self-Funded Plans, Inc. a Dentist's diagnosis, proposed course of treatment, and expected charges. The Dentist may complete this information on a dental claim form. When a Pre-Determination of Benefits has been made, Self-Funded Plans, Inc. will inform the Covered Person, in advance of treatment, as to the estimated amount of any benefits payable under this Plan with respect to the proposed course of treatment.

Benefits for Temporary Work
Benefits for temporary dental service will be considered a part of the final dental service. Benefits paid for temporary service will be deducted from the benefits otherwise payable for the final service.

Alternate Treatment
If alternate services or supplies may be employed to treat a dental condition, Covered Dental Expenses will be limited to the Reasonable and Customary charge for those services or supplies which are customarily employed nationwide in the treatment of the disease or Injury and are recognized by the profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account the current total oral condition of the covered family member.

Covered Dental Expenses
Covered Dental Expenses are the Reasonable and Customary Charges of a Dentist for services and supplies listed below; but only to the extent that the Plan determines that the services rendered and supplies furnished are appropriate and meet professionally recognized national standards of quality.
The following is a complete list of those dental services which will be considered as Covered Dental Expenses; however, expenses that are incurred for the performance of any dental service not listed below will be considered a Covered Dental Expense only if the Plan Administrator agrees in writing to accept such expenses as Covered Dental Expenses. If the Plan Administrator so agrees, the benefits that are payable will be consistent with a payment for such similar Covered Dental Expenses that would provide the least costly professionally adequate treatment.

Type I Services
1. Oral examination, but not more than two examinations in any calendar year.
2. Prophylaxis, but not more than two (2) prophylaxes in any calendar year.
3. Dental x-rays required in connection with the diagnosis of a specific condition requiring treatment; also other dental x-rays (other than full-mouth x-rays), but not more than two (2) sets of supplementary bitewing x-rays in any calendar year.
4. Topical application of sodium or stannous fluoride. Such charges will be covered once in a calendar year.
5. Emergency palliative treatment.
6. Space maintainers for Covered Persons under age nineteen (19) (or twenty-five) for Eligible Dependent children who are Eligible Dependents.

Type II Services
1. Oral surgery (excluding osseous surgery and any charges which are covered under the medical benefits plan), including necessary pre-operative treatment during Hospital confinement and customary post-operative treatment furnished in connection with oral surgery. This also includes extraction of one or more teeth, except when done in connection with or in preparation for orthodontic services, and alveoplasty and tooth replantation.
2. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or fractured teeth.

3. Anesthetics administered in connection with oral surgery.
4. Endodontic treatment, including root canal therapy.
5. Injections of antibiotic drugs and application of desensitizing medication by the attending Dentist.
6. Repair or recementing of crowns, inlays, onlays, bridgework, or dentures; or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, not to exceed one relining or rebasing in any period of thirty-six (36) consecutive months.
7. Tests and laboratory examinations including bacteriologic cultures, pulp vitality tests and diagnostic casts (study models).
8. Full mouth x-rays once in any period of thirty-six (36) consecutive months.

Type III Services

1. Gingivectomy and osseous surgery and treatment of periodontal and other diseases of the gums and tissues of the mouth.
2. Inlays, onlays, gold fillings, or crown restorations to restore diseased of fractured teeth, but only when the tooth, as a result of extensive caries of fracture cannot be restored to proper function with an amalgam, silicate, acrylic, synthetic porcelain or composite restoration.
3. Initial installation of removable partial or complete dentures.
4. Initial installation of bridgework.
5. Replacement of an existing denture or bridgework by a new denture or bridgework, or the addition of teeth to an existing removable partial denture or to a fixed partial denture, but only if
    a. the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed;
    b. the existing denture or bridgework cannot be made serviceable, and the denture or bridgework was installed at least five years prior to its replacement; or
    c. the existing denture is an immediate temporary denture which cannot be made permanent, and replacement by a permanent removable denture takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.

Orthodontic Services

Orthodontic Services are only provided for Covered Persons under age nineteen (19), or age twenty-five (25) for Eligible Dependent children. The eligible charges under this benefit are those described below. The term Orthodontic Procedure means the use of active appliances to move teeth, to correct faulty position of teeth (malposition); or abnormal bite (malocclusion). Appliances for temporomandibular joint disturbances and appliances to control harmful habits are covered as orthodontic services. An Orthodontic Treatment Plan means a Dentist's report, on a form approved by the Plan, that states the class of malocclusion or malposition; recommends and describes needed treatment by orthodontic procedures; estimates the duration of the treatment; estimates the total charge for the treatment; and includes cephalometric x-rays, study models and any other supporting evidence that the Plan may reasonably require.

When Expenses Are Deemed to be Incurred

Expenses are deemed to be incurred as of the date dental care is performed, except as provided below:

1. Expenses for restorations shall be deemed incurred on the first date of preparation of the tooth or teeth involved, provided the person remains continuously covered during the course of treatment.
2. Expenses or charges for endodontic services shall be deemed incurred on the date the specific root canal procedure commenced, provided the person remains continuously covered during the course of treatment.
3. Expenses for fixed bridgework, crowns, inlays or restorations shall be deemed incurred on the first date of preparation of the tooth or teeth involved, provided the person remains continuously covered during the course of treatment.
4. Expenses for full or partial dentures shall be deemed incurred on the date the final impression is taken, provided the person remains continuously covered during the course of treatment.
5. Expenses for rebase of an existing partial or complete denture shall be deemed incurred on the first day of preparation of the rebase of such denture, provided the person remains continuously covered during the course of treatment.
6. The orthodontia benefit will be divided equally over the number of months of treatment planned.

Dental Plan Limitations and Exclusions

Dental Expense Benefits do not cover expenses incurred for any of the following:

1. Charges made by other than a Dentist, except that cleaning or scaling of teeth may be performed by a licensed Dental Hygienist, if such treatment is rendered under the supervision and direction of the Dentist.
2. Charges for dental care which is provided solely for the purpose of improving appearance, when form and function of the teeth are satisfactory and no pathological condition exists, including charges for personalization or characterization of dentures.
3. Charges for facings on pontics or crowns posterior to the second bicuspid.
4. Charges for sealants or education or training in, and supplies used for dietary or nutritional counseling, personal oral hygiene or dental plaque control.
5. Charges for dental care which does not meet the standards of dental practice accepted by the American Dental Association.
6. Charges for any spare, duplicate or replacement prosthetic device or any other duplicate dental appliance within five (5) years of the insertion or placement of the original prosthetic device or dental appliance.
7. Charges for any adjustment or repair to a denture which is performed within six (6) months of the installation of the denture.
8. Charges for implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants.
9. Charges for periodontal splinting of teeth except for treatment of trauma.
10. Charges for procedures, appliances or restorations to increase the vertical dimensions or restore or maintain occlusion or stabilize periodontally involved teeth except as specifically included as eligible expenses. Such procedures include but are

not limited to, equilibration, periodontal splinting, restoration of tooth structure lost from wear, rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion.

11. Charges for drugs or medication, including prescriptions, other than injection of antibiotics and application of desensitizing medication by the Dentist.
12. Charges, if any, that are included as covered medical expenses.
13. Charges which were incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.
14. Charges for treatment arising out of or in the course of any employment or occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Workers' Compensation or occupational disease law, whether or not any coverage for such benefits is actually in force.
15. Charges for dental care which is furnished while a person is confined in a Hospital operated by the United States Government or any agency thereof, or dental care for which the person would not be required to pay if there were no benefits.
16. Charges resulting from any intentionally self-inflicted Injury, unless due to domestic violence or a medical condition, and charges for Illness or Injury caused by or contributed to by engaging in an illegal occupation or by committing or attempting to commit a felony.
17. Charges for any services received as a result of Injury or Illness due to an act of war which has occurred after the effective date of the Covered Person's coverage, or caused during service in the armed forces of any country, or arising out of participation in a riot.
18. Charges incurred which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.
19. Charges for the completion of claim forms, medical reports or certifications required by the Plan.
20. Charges for dental care not included in the list of defined eligible expenses.
21. Charges made by a Dentist or Dental Hygienist who normally lives in the Covered Person's home, or is a Close Relative.
22. Charges which are in excess of the Reasonable and Customary Charge of the least expensive alternate service or material consistent with adequate dental care, when such alternative services or materials are customarily provided.

VISION LIMITATIONS AND EXCLUSIONS

There is no coverage for services and supplies for any of the following charges:

1. Charges for occupational accidents or Illnesses, or charges that are also eligible expenses covered by Workers' Compensation.
2. Charges for services provided or paid for by any government or its agencies.
3. Charges for any services received as a result of Injury or Illness due to an act of war which has occurred after the effective date of the Covered Person's coverage, or caused during service in the armed forces of any country.
4. Charges incurred which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.
5. Charges for medical or surgical treatment of the eyes.
6. Charges for lost or stolen lenses and frames.
7. Charges for orthoptics, vision training or subnormal vision aids.
8. Charges for services and supplies not listed as a covered item.
9. Charges for cosmetic needs, such as oversized frames or lenses; coated or tinted lenses, blended lenses and cosmetic contact lenses in excess of the Plan's allowance.
10. Lenses and frames furnished under this Plan which are lost or broken will not be replaced, except at the normal intervals when services are otherwise available.
11. Charges for services rendered by a Close Relative.
12. Charges which were incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.
13. Charges which are covered under the Medical Benefits plan.
14. Charges for any lens options such as UV Coating, Tint, Scratch-Resistance, Standard Polycarbonate, Standard Progressive, Standard Anti-Reflective and other add-ons and services.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

All Eligible Employees who are enrolled on the effective date of the Plan will be covered on that date.
New Eligible Employees who are enrolled will be covered on the first day of the month coinciding with or next following the date they become Eligible Employees. Eligible Employees who return to work following a reduction in force will be covered on the date they return to work. If an Employee for whom coverage is contributory fails to enroll within thirty (30) days of becoming eligible, he will be treated as a Late Enrollee.

Eligible Employees who return to work following a tour of active duty in a United States Military Reserve Unit will be covered on the date they return to work. Such Eligible Employees will continue to be covered under the Plan as if there had been no break in service.
Coverage must be in effect for an Eligible Employee in order for coverage to take effect for an Eligible Dependent.
Eligible Dependents who are enrolled will be covered on the same date as the Eligible Employee or the date such dependent is acquired (whichever is later), subject to the terms described in the following paragraphs. If an Eligible Dependent for whom coverage is contributory is not enrolled within thirty (30) days of becoming eligible, the Eligible Dependent will be treated as a Late Enrollee upon subsequent enrollment in the Plan, unless he is a Special Enrollee.
If two Eligible Employees are married to each other, and one is covered as an Eligible Dependent of the other, if the Eligible Employee who is carrying the dependent coverage terminates, coverage can be transferred to the Eligible Dependent who is still an Eligible Employee, and no additional waiting period will apply, provided coverage is continuous. Credit will be given toward maximums, deductible, etc.
In the event that an Eligible Employee or Eligible Dependent is a Late Enrollee, he may complete enrollment during the annual open enrollment period specified by the Plan Administrator (which is the month of August of any year) and coverage will be effective on the next following October 1st.
Random eligibility audits will be performed for existing members, and proof of eligibility will be required (to include but not be limited to marriage certificates, birth certificates and adoption papers). All employees hired after the effective date of this law will be required to provide proof of eligibility for all members.

Special Enrollee with Respect to Loss of Other Coverage.

a. An Eligible Employee may be enrolled as a Special Enrollee if he is eligible (but not enrolled) for coverage under the terms of the Plan and when enrollment in the Plan was previously offered and declined by him, he was covered under another group health plan or had other health insurance coverage;
b. An Eligible Dependent may be enrolled as a Special Enrollee if he is eligible (but not enrolled) for coverage under the terms of the Plan and, when enrollment in the Plan was previously offered and declined, he was covered under another group health plan or had other health insurance coverage;
c. An Eligible Employee and Eligible Dependent(s) may be enrolled as Special Enrollees if they are eligible (but not enrolled) for coverage under the terms of the Plan and when enrollment in the Plan was previously offered and declined, they were covered under another group health plan or had other health insurance coverage;

A Special Enrollee described in paragraphs a through c above is eligible to enroll in the Plan if, when enrollment in the Plan was declined, the Special Enrollee had COBRA continuation of coverage under another plan and the COBRA continuation of coverage under that other plan has since been exhausted; or if the other coverage that applied to the Special Enrollee when enrollment was declined was not under a COBRA continuation of coverage provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or Employer contributions towards the other coverage have been terminated. For the purposes of this paragraph, "loss of eligibility for coverage" includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment and any loss of eligibility after a period that is measured by reference to any of the foregoing. However, loss of eligibility does not include a loss due to failure of an individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or intentional misrepresentation of a material fact in connection with the Plan). For purposes of this paragraph, exhaustion of COBRA continuation of coverage means that an individual's COBRA continuation of coverage ceases for any reason other than the failure of the individual to pay premiums on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan). An individual is considered to have exhausted COBRA continuation of coverage if such coverage ceases (a) due to the failure of the Employer or other responsible entity to remit premiums on a timely basis, or (b) when the individual no longer resides, lives or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation of coverage available to the individual. Proof of Special Enrollee status is required.
In the event of the enrollment of a Special Enrollee as described in paragraphs a through c above, the Eligible Employee is required to enroll himself or his dependents (who are Special Enrollees), not later than thirty (30) days after the exhaustion or termination of the other coverage. Coverage for such Special Enrollees will be effective on the day following loss of coverage.
A person is eligible to enroll in the Plan if (1) the employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the employee requests coverage under the plan within 60 days after the termination, or (2) the employee or dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the plan within 60 days. Such coverage will be effective on the day following the date coverage is lost under Medicaid or CHIP.

Special Enrollee with Respect to Certain Eligible Dependents.

a. An Eligible Employee may enroll as a Special Enrollee if he is eligible (but not enrolled) for coverage under the terms of the Plan and he would be a Covered Person in the Plan but for a prior election by him not to enroll in the Plan and he acquires an Eligible Dependent through marriage, birth, adoption or Placement for adoption.
b. An Eligible Dependent who is the spouse of the Eligible Employee may enroll as a Special Enrollee if the Eligible Dependent becomes the spouse of the Eligible Employee or the Eligible Employee and the Eligible Dependent are married and a child becomes an Eligible Dependent of the Eligible Employee through birth, adoption or Placement for adoption.
c. An Eligible Employee and an Eligible Dependent who is the Eligible Employee's spouse may enroll as Special Enrollees if the Eligible Employee would be a Covered Person in the Plan but for a prior election by the Eligible Employee not to enroll in the Plan and either the Eligible Dependent and the Eligible Employee become married or the Eligible Employee and Eligible

Dependent are married and a child becomes an Eligible Dependent of the Eligible Employee through birth, adoption or Placement for adoption.

d. An Eligible Dependent who is a dependent child of the Eligible Employee may enroll as a Special Enrollee if the Eligible Dependent becomes an Eligible Dependent of the Eligible Employee through marriage, birth, adoption or Placement for adoption.

e. An Eligible Employee and an Eligible Dependent who is a dependent child of the Eligible Employee may enroll as Special Enrollees if the Eligible Employee would be a Covered Person in the Plan but for a prior election by the Eligible Employee not to enroll in the Plan and the Eligible Dependent becomes an Eligible Dependent of the Eligible Employee through marriage, birth, adoption or Placement for adoption.

In the event of the enrollment of a Special Enrollee described in paragraphs a through e above, the Eligible Employee is required to enroll himself or his dependents (who are eligible to enroll as Special Enrollees), not later than thirty (30) days after the date of the marriage, birth, adoption or Placement for adoption. In the event of the enrollment of a Special Enrollee described in paragraph d above who is a Special Enrollee for the reason of his birth, the Eligible Employee is required to enroll such Special Enrollee not later than one (1) year following the date of birth provided the Eligible Employee was already enrolled for dependent coverage. Proof of Special Enrollee status is required. Coverage for such Special Enrollees will be effective as follows:

1. Special Enrollees who enroll as Special Enrollees due to the birth, adoption or Placement for adoption of an Eligible Dependent will be Covered Persons from the moment of birth, adoption or Placement for adoption of the Eligible Dependent.
2. Special Enrollees who enroll as Special Enrollees due to marriage of an Eligible Dependent to an Eligible Employee will be Covered Persons from the date of marriage.

If a dependent is acquired other than at the time of his birth, due to a court order or decree, that dependent will be considered an Eligible Dependent of the Eligible Employee from the date of such court order or decree, provided this new dependent is properly enrolled as a dependent of the Eligible Employee within thirty (30) days of the court order or decree. However, if a dependent child is acquired as a result of adoption, that child will be covered the day he is Placed with the adopting parents during the period before the adoption becomes final.

This Plan will follow the ACA requirements for eligibility. This means the Employer will determine what measurement periods and stability periods (as defined by the ACA) it will follow, and based on this analysis, coverage will be allowed even if it does not meet the eligibility provisions outlined herein.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 PROVISION

If an Eligible Employee who is enrolled in the Plan is absent from work by reason of service in the uniformed services, the Eligible Employee and his Eligible Dependents, if any, who are enrolled in the Plan may elect to continue coverage under the Plan for a maximum period equal to the lesser of (i) the 24-month period beginning on the date on which the Eligible Employee's absence begins, or (ii) the day after the date on which the Eligible Employee fails to apply for or return to a position of employment as determined by the Employer under the federal Uniformed Services Employment and Reemployment Rights Act of 1994, as may be amended from time to time (the "USERRA.") A person who is eligible to elect to continue health-plan coverage under this provision and who so elects, is required to pay 102 percent of the cost to participate in the Plan (determined in the same manner as the cost to participate in COBRA continuation coverage), except that in the case of an Eligible Employee who performs service in the uniformed services for less than thirty-one (31) days, such person shall pay the employee contribution, if any, for such coverage. Except in the case of any Illness or Injury determined by the Secretary of Veterans' Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services, in the case of an Eligible Employee whose coverage under the Plan was terminated by reason of service in the uniformed services, any otherwise applicable exclusion or waiting period under the Plan shall not be imposed in connection with the reinstatement of such coverage upon reemployment under the USERRA if that exclusion or waiting period would not have been imposed under the Plan had coverage of such Eligible Employee by the Plan not been terminated as a result of such service. This paragraph applies to the Eligible Employee and to his Eligible Dependents, if any. "Service in the uniformed services" for purposes of this provision shall mean the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

TERMINATION OF COVERAGE

The coverage of any Covered Person shall terminate on the earliest of the following dates:

1. The date of termination of the Plan.
2. The end of the month in which the Eligible Employee ceases to be in an eligible employee class. However, if an Eligible Employee is no longer an Eligible Employee due to an approved leave of absence, coverage will continue while the approved leave of absence continues, for up to a maximum of twenty-four (24) months following the date he was last an Eligible Employee, provided he makes the required contribution for coverage.
3. The date all coverage or certain benefits are terminated on a particular class by modification of the Plan.
4. The date the Employee fails to make any required contribution for coverage.
5. With respect to an Eligible Dependent, the date coverage terminates for the Eligible Employee or the date such Dependent no longer meets the qualifications of an Eligible Dependent.

This Plan is in compliance with Michelle's law. If a child qualifies as an Eligible Dependent due to being a Full-Time Student, and such child is forced to take a Medically Necessary Leave of Absence from school due to a serious Illness or Injury, coverage can be

continued for such Eligible Dependent. A “Medically Necessary Leave of Absence” is defined as a leave of absence from a post-secondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965) or any other change in enrollment at such an institution that begins while the student is suffering from a serious Illness or Injury; is Medically Necessary; and causes the student to lose student status for purposes of coverage under the terms of the Plan. Coverage will be continued until one year after the first day of the leave of absence or the date coverage would otherwise terminate under the terms of the Plan, whichever comes first. The Plan must receive a written certification by the treating Physician of the dependent child which states that the child is suffering from a serious Illness or Injury and that the leave of absence is Medically Necessary. The child taking the leave described herein is entitled to the same benefits as if the child had continued to be covered as a student who did not take leave. This Plan provides no greater rights than what Michelle’s Law requires (nothing in this Plan is intended to expand the rights of any participant beyond the law’s requirements). If Michelle’s Law is amended, this Plan will follow such legislation.

THE FAMILY AND MEDICAL LEAVE ACT OF 1993

In the event that the Employer approves a leave under The Family and Medical Leave Act of 1993 (FMLA) for an Eligible Employee, that Eligible Employee may receive up to twelve (12) work weeks of continued benefits under this Plan while on such leave (provided that required contributions, if any, are made by or on behalf of that Eligible Employee). An Eligible Employee returning from an approved leave under the FMLA who did not continue benefits under this Plan during such leave, will be covered on the date he returns to work. In addition, such person will continue to be covered under the Plan as if there had been no break in service. In the event that an Eligible Employee does not continue benefits under this Plan throughout an approved FMLA leave, the Continuation of Coverage Provision (COBRA) outlined in the Plan will apply to such Eligible Employee in accordance with the following paragraph. The Continuation of Coverage Provision (COBRA) outlined in the Plan will apply on the earlier of:

1. The date that the Eligible Employee informs the Employer of his intent not to return from such leave; or
2. The date that the Eligible Employee does not return from such leave after the leave is over.

This provision shall include all revisions made to the FMLA regulations, including the following types of leave:

1. Service member family caregiver leave that provides up to 26 weeks of protected unpaid leave in a single 12-month period to an Eligible Employee who is the spouse, child, parent or next-of-kin of a covered service member to care for the service member injured during active duty.
2. A leave of up to 12 weeks in a 12-month period as a result of any “qualifying exigency” because the Eligible Employee’s spouse, child or parent is on active duty (or has been notified of an impending call to duty) in the Armed Forces in support of a “contingency operation.”

CONTINUATION OF COVERAGE PROVISION (COBRA)

Under certain circumstances (as outlined in this section), an Eligible Employee or Eligible Dependent may elect to continue certain benefits under this Plan, at the Covered Person's own expense, after that person is no longer eligible for coverage. This Plan provides no greater COBRA rights than what COBRA requires (nothing in this Plan is intended to expand the rights of any participant beyond COBRA’s requirements). This COBRA provision shall be modified if there are changes in the COBRA legislation.

ELIGIBILITY FOR CONTINUATION. A person who is eligible for continuation coverage is called a "Qualified Beneficiary." The events making a person eligible for continuation coverage are called "Qualifying Events." For a covered employee to become a Qualified Beneficiary, the employee must become ineligible for group coverage because of a Qualifying Event consisting of a termination of the employee's employment (other than because of gross misconduct) or because of a reduction in the number of hours worked. For a covered spouse or covered child to become a Qualified Beneficiary, the spouse or child must become ineligible for group coverage because of one of the following Qualifying Events:

1. Death of the Eligible Employee;
2. Termination of the Eligible Employee's employment (other than because of the Employee's gross misconduct) or reduction in the number of hours of employment;
3. Divorce or legal separation of the Eligible Employee from the Eligible Employee’s spouse. Also, if the Eligible Employee reduces or eliminates coverage for a spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event for the Eligible Dependent spouse and/or children even though their coverage was reduced or eliminated before the divorce or legal separation;
4. The Eligible Employee becoming entitled to Medicare; or
5. A dependent child ceasing to meet the definition of "Eligible Dependent."

Provided the Eligible Employee has elected and is covered by continuation coverage, newborn children of the Eligible Employee and children Placed for adoption with the Eligible Employee on or after the date of the Qualifying Event that are properly enrolled as Eligible Dependents will be considered Qualified Beneficiaries.

TYPE OF COVERAGE TO BE CONTINUED. A Qualified Beneficiary is entitled to the same coverage that is available to other similarly situated persons covered under this Plan who have not experienced a Qualifying Event. Proof of good health will not be required.

PERIOD OF CONTINUATION. A Qualified Beneficiary may elect to continue the group coverage beyond the Qualifying Event until the earliest of the following:

1. The end of:
    a. eighteen (18) months, in a case where the Qualifying Event was a termination of employment or a reduction in hours; or

b. thirty-six (36) months, for other Qualifying Events;

2. The date on which the Employer ceases to provide any group health plan to any Eligible Employee;
3. The date on which coverage ceases under the Plan due to the Qualified Beneficiary's failure to make timely payment of any required premium;
4. The date on which the Qualified Beneficiary first becomes, after the date of election:
   a. a covered person under any other group health plan. If the other group health plan contains an exclusion or limitation relating to a pre-existing condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for continuation coverage as long as the exclusion or limitation relating to the pre-existing condition has not been satisfied or deemed to have been satisfied; or
   b. entitled to benefits under Medicare (under Part A, Part B, or both).
5. In the case of a Qualified Beneficiary who is determined by the Social Security Administration (hereinafter SSA) to be disabled, then continuation coverage may continue for up to twenty-nine (29) months for all Qualified Beneficiaries. This extension is available only for Qualified Beneficiaries who are receiving COBRA coverage because of a Qualifying Event that was the Eligible Employee's termination of employment or reduction of hours. The disability must have started at some time before the sixty-first (61st) day after the covered employee's termination of employment or reduction of hours, and must last at least until the end of the period of COBRA coverage that would be available without the disability extension. The disability extension is available only if the Qualified Beneficiary notifies the Plan in writing of the SSA determination of disability (based on the Notification of Qualifying Event procedures outlined herein) within sixty (60) days after the latest of (1) the date of the SSA disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; (3) the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours; or (4) the date on which the Qualified Beneficiary is informed, through the Plan's summary plan description or the general COBRA notice, of his or her obligation to provide notice and the procedures for providing such notice. The Qualified Beneficiary must also provide this notice within eighteen (18) months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. Required notification procedures are outlined in the section entitled "Notification of Qualifying Event." The Employer is authorized to charge the Qualified Beneficiary an increased premium for continuation coverage extended beyond eighteen (18) months pursuant to this provision.

   In the event that the Qualified Beneficiary is determined by SSA to be no longer disabled, the Qualified Beneficiary shall notify the Employer of this determination within thirty (30) days. This notification shall be satisfied by sending a copy of the SSA letter stating that the Qualified Beneficiary is no longer considered to be disabled by SSA.

   If during extended coverage for disability (continuation of coverage months nineteen [19] - twenty-nine [29]) a Qualified Beneficiary is determined to be no longer disabled under The Act, continuation coverage shall terminate the last day of the month following thirty (30) days from the date of SSA's final determination that the Qualified Beneficiary is no longer disabled.

PREMIUM FOR CONTINUATION. The Employer will determine the amount of premium which will be charged for continuation coverage. Premium may, at the election of the payer, be made in monthly installments. Without further notice from the Employer, the Covered Person must pay the monthly premium by the last day of the period before the period for which coverage is to be effective. A thirty (30) day grace period is available before coverage will be retroactively terminated. If election of continuation coverage is made after the Qualifying Event, payment must be made (in an amount that is current, when taking the grace period into account) within forty-five (45) days of the date of election. No claim will be payable under this provision until the premium is received from, or on behalf of, the Covered Person. If mailed, the premium is considered to have been made on the date that it is postmarked. If hand-delivered, the premium is considered to have been made when it is received by the COBRA department at the Plan Supervisor's office. If the check is returned for insufficient funds, the premium will be deemed to be unpaid.

ELECTION PERIOD. A Qualified Beneficiary may elect continuation coverage during the Election Period. The Election Period means the period which:

1. Begins not later than the date on which coverage terminates under the group plan because of the Qualifying Event;
2. Is of at least sixty (60) days duration; and
3. Ends not earlier than sixty (60) days after the later of:
   a. the date coverage terminates under this Plan because of the Qualifying Event; or
   b. the date of the notice offering the election of continuation of coverage.

MULTIPLE QUALIFYING EVENTS. If during continuation coverage a Qualified Beneficiary experiences a subsequent Qualifying Event and the original Qualifying Event was termination of the Eligible Employee's employment (other than for gross misconduct) or reduction in the number of hours of the Eligible Employee's employment, then that Qualified Beneficiary may be eligible to participate in continuation coverage for up to thirty-six (36) months from the date of the original Qualifying Event.

When Plan coverage is lost due to the end of employment or reduction of the Eligible Employee's hours of employment, and the Eligible Employee became entitled to Medicare benefits less than eighteen (18) months before the Qualifying Event, COBRA coverage for the Qualified Beneficiaries (other than the Eligible Employee) who lose coverage as a result of the Qualifying Event can last up to thirty-six (36) months after the date of Medicare entitlement. For example, if an Eligible Employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the Qualifying Event (thirty-six [36] months minus eight [8] months). This COBRA coverage period is available only if the Eligible Employee becomes entitled to Medicare within eighteen (18) months before the termination or reduction of hours.

To report a subsequent Qualifying Event, the Qualified Beneficiary must send written documentation of the second Qualifying Event to the Employer within sixty (60) days of the later of (a) the occurrence of such Qualifying Event, or (b) the date on which the Qualified Beneficiary loses (or would lose) coverage as a result of the Qualifying Event, or (c) the date on which the Qualified

Beneficiary is informed, through the Plan's summary plan description or the general COBRA notice, of his or her obligation to provide notice and the procedures for providing such notice.
Required notification procedures are outlined in the section entitled "Notification of Qualifying Event." If the required notification procedures are not followed, then there will be no extension of COBRA due to a second Qualifying Event.
NOTIFICATION OF QUALIFYING EVENT. The Covered Person is responsible for notifying the Employer of the occurrence of the following Qualifying Events

1. divorce or legal separation of the Eligible Employee from the Eligible Employee's spouse;
2. a dependent child ceasing to be an Eligible Dependent,
3. second qualifying events, entitling certain Qualified Beneficiaries to an extension of the COBRA maximum coverage period for up to thirty-six (36) months;
4. a Qualified Beneficiary's disability, entitling Qualified Beneficiaries to an eleven (11) month extension of the COBRA maximum coverage period for up to twenty-nine (29) months; and
5. the end of a disabled Qualified Beneficiary's disability (such that the eleven [11] month disability extension is no longer available).

Such notification must be made within sixty (60) days of the later of (a) the occurrence of such Qualifying Event; (b) the date on which there is a loss of coverage; (c) in the case of a Qualified Beneficiary's disability, the date of the SSA disability determination; or (d) the date on which the Qualified Beneficiary is informed, through the Plan's summary plan description or the general COBRA notice, of his or her obligation to provide notice and the procedures for providing such notice.
To report such Qualifying Events, the Covered Person must submit written documentation of the change to the **Treasurer or Assistant Treasurer/Payroll and Benefits** within the time period noted in this paragraph. The Covered Person must include copies of the relevant paperwork (i.e. the paperwork outlining the Medicare determination of disability, a copy of the divorce decree, etc). If the notification is deficient, the Employer will request more complete information; if this request for information is not responded to within the required time period, the Notification will be rejected.
HEALTH COVERAGE TAX CREDIT. Certain individuals may be eligible for a federal income tax credit that can help with qualified monthly COBRA premium payments. Guidelines are available under the IRS.gov website.
FMLA. If an Eligible Employee takes FMLA leave and does not return to work at the end of the leave, the Eligible Employee (and the Eligible Employee's Eligible Dependents, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage within 18 months because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave). COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours.
ELECTION PROCEDURES. To elect COBRA, the Qualified Beneficiary must complete the Continuation Coverage Election Form and submit it to the Plan Supervisor. Under federal law, the Qualified Beneficiary must have sixty (60) days after the date of the COBRA election notice provided to the Qualified Beneficiary at the time of his Qualifying Event to decide whether he wants to elect COBRA under the Plan. The Continuation Coverage Election Form must be completed in writing and mailed or hand-delivered to the address shown on the form. If mailed, the election must be postmarked (and if hand-delivered, the election must be received by the individual at the Plan Supervisor's office) no later than sixty (60) days after the date of the COBRA election notice provided to the Qualified Beneficiary at the time of the Qualifying Event. If the election is not submitted within these time periods, the individual will lose his right to elect COBRA. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail. If COBRA is rejected before the due date, the Qualified Beneficiary may change his mind as long as he furnishes a completed Election Form before the due date.

DEFINITIONS OF KEY WORDS

ALCOHOLISM/DRUG ADDICTION TREATMENT FACILITY: A part of a Hospital devoted primarily to alcoholism or drug addiction treatment or a facility primarily established for alcoholism or drug addiction treatment and specifically licensed for that purpose by the jurisdiction in which it is located.
AMBULATORY SURGICAL CENTER: Any public or private 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 whenever a patient is in the facility, and which does not provide services or other accommodations for patients to stay overnight.
BRAND NAME DRUG: A non-Generic Drug.
CLOSE RELATIVE: The spouse, parent, brother, sister, or child of the Covered Person, or the spouse of the Covered Person's parent, brother, sister, or child.
CONVALESCENT FACILITY: An institution which is licensed to provide, on an Inpatient basis, for persons convalescing from an Injury or Illness, professional nursing services and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities. Also called a Skilled Nursing Facility.
COSMETIC SURGERY: Surgery performed for the purpose of improving appearance rather than for restoring bodily function.
COVERED PERSON: The Employee or any person who is defined in this Plan as an Eligible Dependent of the Employee and is covered for benefits under this Plan.
CUSTODIAL CARE: The term "Custodial Care" means any type of service, including room and board and/or institutional service, which is designed essentially to assist a Covered Person, whether disabled or not, in the activities of daily living. Such services

include assistance in walking or getting in and out of bed, bathing, dressing, feeding, preparation of special diets and supervision over medication which can normally be self-administered.

DENTAL HYGIENIST: Someone who is currently licensed to practice dental hygiene and is acting under the supervision and direction of a Dentist.

DENTIST: A duly licensed Dentist practicing within the scope of the dental profession and any other Physician furnishing any dental services which such Physician is licensed to perform.

DURABLE MEDICAL EQUIPMENT: Equipment that meets all of the following tests:

1. Is able to withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is not generally useful to a person in the absence of Illness or Injury; and
4. Is covered under Medicare guidelines.

ELIGIBLE DEPENDENTS (applies to medical only): The Eligible Employee's spouse, unless divorced, and all children from birth to 26 years of age. The term "children" will include only natural children; stepchildren; legally adopted children (including children Placed with the adopting parents during the period before the adoption becomes final); or children for whom the Eligible Employee is the child's legal guardian. Such children do not need to live with the Eligible Employee or to be financially dependent upon the Eligible Employee for support. Such children do not need to be full-time students, and they are also eligible if they are married and/or employed. Dependents of such children will not be eligible for coverage.

A child who is physically or mentally incapable of self-support upon attaining the age of 26 may be considered an Eligible Dependent while remaining incapacitated, unmarried and continuously covered under the Plan. To continue a child under this provision, proof of incapacity may be required from time to time.

The term "Eligible Dependent" shall not include any dependent who is covered as an Eligible Employee. Also, if both parents are employed by the Employer, children will be covered only as Eligible Dependents of one parent.

In order for a child to be covered under these provisions, the Eligible Employee must also be enrolled for coverage.

In addition to the children defined above, the Plan will also cover children who do not meet the criteria outlined in the first paragraph but who are related by blood or marriage and are residing with the Eligible Employee. Such children will be covered to age 25.

In accordance with the Ohio law, eligibility will be extended for children to age 28 for medical coverage. To be eligible, a child must be unmarried and (1) the natural child, stepchild or legally adopted child of the Eligible Employee; (2) a resident of Ohio or a full-time student; (3) not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and (4) not eligible for Medicaid or Medicare. Such children do not need to live with the Eligible Employee or to be financially dependent upon the Eligible Employee for support. Children who fit into the parameters outlined above (and who do not otherwise meet the definition of Eligible Dependent outlined in the plan document) may enroll for coverage when the Plan is notified that the child has experienced a change in circumstances and has become newly eligible for coverage under state law. Such children will be treated as a Special Enrollees under this Plan and will also be able to enroll for coverage during the open enrollment period outlined in the Plan. However, the dependents of such children will not be eligible for coverage under this provision. To enroll children for this coverage, the parent should request the appropriate enrollment materials from the Employer. Children who come under this category will be charged a premium for coverage, and they must pay the monthly premium by the last day of the period before the period for which coverage is to be effective. A thirty (30) day grace period is available before coverage will be retroactively terminated. No claim will be payable under this provision until the premium is received from, or on behalf of, the Covered Person. If mailed, the premium is considered to have been made on the date that it is postmarked. If hand-delivered, the premium is considered to have been made when it is received by the enrollment department at the Plan Supervisor's office. If the check is returned for insufficient funds, the premium will be deemed to be unpaid. When the child reaches age 28 and loses coverage under this Plan, the child may elect COBRA coverage. If there are any changes to this law, this Plan will automatically be amended to be in compliance.

ELIGIBLE DEPENDENTS (applies to dental and vision only): The Eligible Employee's spouse, unless divorced, and all unmarried children from birth to nineteen (19) years of age. In addition, children will be considered as Eligible Dependents from age nineteen (19) to twenty-five (25) if they are (1) unmarried, (2) not eligible for other group coverage as an employee, (3) living with the Eligible Employee in a parent-child relationship and (4) dependent upon the Eligible Employee for financial support within the meaning of the Internal Revenue Code. The term "children" will include only natural children; stepchildren; legally adopted children (including children Placed with the adopting parents during the period before the adoption becomes final); children permanently residing in the household of which the Eligible Employee is the head and actually being supported by the Eligible Employee within the meaning of the Internal Revenue Code (provided the Eligible Employee is related to the child by blood or marriage or is the child's legal guardian); and children for whom an Eligible Employee or the Eligible Employee's spouse is responsible by court decree for principal support or medical care.

ELIGIBLE EMPLOYEES: All full-time Employees who customarily work at least thirty (30) hours per week, or employees meeting the requirements set forth in the negotiated collective bargaining agreement are eligible to be covered by the Plan. Eligible Employees who begin employment after the effective date of the Plan will be covered after they have satisfied the requirements of the Eligibility and Effective Date of Coverage provisions of this Plan.

EMERGENCY CARE: Treatment for a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. placing the health of the individual or, with respect to a pregnant woman, the health of her unborn child, in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

EMERGENCY HOSPITAL ADMISSION: An Emergency Hospital Admission is defined as an admission for Inpatient Hospital confinement for a condition which, unless immediately treated only on an Inpatient basis, would jeopardize the patient's life or cause serious impairment to the patient's bodily functions.

EMPLOYER: The Employer is Carrollton Exempted Village School District.

ESSENTIAL HEALTH BENEFITS: Such benefits include ambulatory patient services, emergency services, hospitalization, maternity and newborn care; mental health and substance disorders; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services, chronic-disease management and pediatric services, including oral and vision care.

EXPERIMENTAL OR INVESTIGATIONAL: One or more of the following is true of a treatment, procedure, device, drug, or medicine:

1. It cannot be lawfully marketed without U.S. Food and Drug Administration approval; and approval for marketing for the condition treated has not been given at the time the device, drug or medicine is furnished;
2. Reliable evidence shows that to determine its maximum tolerated dose, toxicity, safety, efficacy (or efficacy as compared with the standard means of treatment or diagnosis):
    a. It is undergoing phase I, II, or III clinical trials or is under study; or
    b. further clinical trials or studies are needed, according to the experts' consensus of opinion.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; or the written protocol or written informed consent used by the treating facility (or by another facility studying substantially the same treatment, procedure, device, drug or medicine).

Experimental or Investigational shall also mean any treatments, services, supplies or related expenses that are educational or provided primarily for research; or treatments, procedures, devices, drugs or medicines or other expenses relating to the transplant of non-human organs.

FREESTANDING BIRTHING FACILITY: The term "Freestanding Birthing Facility" means an institution or facility, either free standing or as part of a Hospital with permanent facilities, equipped and operated for the primary purpose of performing maternity deliveries and to which a patient is admitted to and discharged from within a twenty-four (24) hour period.

FREESTANDING DIALYSIS FACILITY: Any freestanding establishment with permanent facilities that are equipped and operated primarily for the purpose of performing peritoneal, renal or other kinds of dialysis, with continuous Physician services and registered professional nursing services whenever a patient is in the facility. Such facility must be accredited as a dialysis facility by the Healthcare Financing Administration (HCFA). For the purpose of this Plan, a facility meeting these requirements will be considered a Freestanding Dialysis Facility by whatever actual name it may be called; however, a facility located on or in conjunction with or in any way made a part of a regular Hospital shall be excluded from the terms of this definition.

GENERIC DRUG: A drug or medicine which is produced and sold under the chemical name or a shortened version; is approved by the U.S. Food and Drug Administration as safe and effective; is produced after the original patent expires; is produced by a company different from the one that first patented the chemical formulation; and costs less than the product produced by the company that first patented the chemical formulation.

HOME HEALTH CARE AGENCY: The term "Home Health Care Agency" means only a public or private agency or organization, or a sub-division thereof, that (a) is primarily engaged in providing skilled nursing and other therapeutic services, (b) has policies established by associated professional personnel, including one or more Physicians and one or more Registered Professional Nurses (R.N.), to govern the services provided under the supervision of such a Physician or nurse, (c) maintains clinical records on all patients, and (d) in cases where the applicable state or local law provides for the licensing of agencies or organizations of this nature, the latter are licensed or approved by the state or local law as meeting the standards established for such licensing. In no event will the term "Home Health Care Agency" include one which is engaged primarily in the care and treatment of mental disease.

HOSPICE: An agency that provides counseling and incidental medical services and may provide room and board to a terminally ill person and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval;
2. It provides 24-hour-a-day, 7-day-a-week service;
3. It is under the direct supervision of a duly qualified Physician;
4. It is an agency that has as its primary purpose the provision of Hospice services;
5. It has a full-time administrator;
6. It maintains written records of services provided to the patient;
7. Its employees are bonded, and it provides malpractice and malplacement insurance; and
8. It is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law.

HOSPITAL: An institution engaged primarily in providing medical care and treatment of ill and injured persons on an Inpatient basis at the patient's expense and which in the opinion of the Plan Administrator meets the tests set forth in 1 or 2 below:

1. It is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations;
2. It meets all the following tests:
    a. it maintains, on the premises, diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of ill and injured persons by or under the supervision of a staff of duly qualified Physicians; and
    b. it continuously provides, on the premises, 24-hour-a-day nursing service by or under the supervision of Registered Professional Nurses (R.N.); and
    c. it is operated continuously with organized facilities for operative surgery on the premises.

The term "Hospital" does not include a hotel, rest home, nursing home, convalescent home, facility for Custodial Care of the mentally ill or of the aged, or an institution primarily for the treatment of drug addiction or alcoholism.

ILLNESS: A bodily disorder, disease, physical Illness, mental infirmity, or functional nervous disorder of a Covered Person.
INJURY: An accidental physical Injury to the body caused by unexpected external violent means. A strain will not be considered due to an Injury.
INPATIENT: A Covered Person shall be considered to be an "Inpatient" if he is admitted to a Hospital, Hospice, or any other covered facility for treatment, and charges are made for room and board to the Covered Person as a result of such treatment. A Covered Person will also be considered to be an "Inpatient" if the confinement is a Partial Confinement as defined herein, or if he is in observation status for a period of twenty-four (24) hours or more.
LATE ENROLLEE: An Eligible Employee or Eligible Dependent who is not enrolled in the Plan on the earliest date possible in accordance with the requirements of the Eligibility and Effective Date of Coverage provisions of this Plan, unless such person is a Special Enrollee.
MEDICALLY NECESSARY: "Medically Necessary" means that there is an Illness or Injury which requires treatment, and the confinement, service or supply used to treat the Illness or Injury is:
1. Required;
2. Generally professionally accepted as the usual, customary, and effective means of treating the Illness or Injury in the United States; and
3. Approved by regulatory authorities such as the Food and Drug Administration and any other such organizations.

Diagnostic x-rays and laboratory tests are "Medically Necessary" when:
1. Performed due to definite symptoms of Illness or Injury; or
2. They reveal a need for treatment.

NURSE-MIDWIFE: A person certified to practice as a Nurse-Midwife, who has an active license as a registered nurse granted by a board of nursing, and who has completed a state approved program for the preparation of Nurse-Midwives.
OUTPATIENT: A Covered Person shall be considered to be an "Outpatient" if he receives medical care, treatment, services or supplies at a clinic, a Physician's office, a Hospice, or a Hospital if not considered an Inpatient at that Hospital (as determined by this Plan's definition of Inpatient).
PARTIAL CONFINEMENT: Partial Confinement means treatment at a covered facility for at least three (3) hours, but no more than twelve (12) hours, in any twenty-four (24) hour period, with a duration of at least three (3) consecutive days.
PHYSICIAN: A person duly licensed under the governing authority to perform the services rendered and covered for benefits under the Plan. Should such person be other than a Medical Doctor, Doctor of Osteopathy, or Doctor of Dental Surgery, the statutes of the applicable jurisdiction require that such person be recognized as a Physician to the extent that he is performing services within the scope of his license. For purposes of this Plan, a licensed social worker working under the supervision of a psychologist or psychiatrist will be considered as a Physician. The Plan will follow the non-discrimination in health care providers required under the Affordable Care Act.
PLACED OR PLACEMENT: The assumption and retention by an Eligible Employee of a legal obligation for total or partial support of a child in anticipation of adoption of such child. The child's Placement terminates upon the termination of such legal obligation.
PLAN: The Plan is the Carrollton Exempted Village School District Health Benefit Plan.
PLAN ADMINISTRATOR: The Plan Administrator is the Employer, which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan connected services. The Plan Administrator is also the Plan Sponsor and named fiduciary.
PLAN SPONSOR: The Plan Sponsor is the Employer.
PLAN SUPERVISOR: The company providing services to the Employer in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it. The Plan Supervisor is Self-Funded Plans, Inc.
PREVENTIVE/MAINTENANCE CARE: Any care that seeks to prevent Illness, prolong life, promote health, enhance the quality of life and/or maintain the optimum state of health after the patient has reached a maximum level of recovery.
REASONABLE AND CUSTOMARY CHARGE (R & C): The Reasonable and Customary Charge for services is based on a relative value system for the types of services performed, taking into consideration the geographic areas where the services are performed, as well as the fees being charged within those geographic areas. The Reasonable and Customary Charge for supplies is based on a relative value system for the types of supplies provided, taking into consideration the geographic areas where the supplies are provided, as well as the fees being charged within those geographic areas. The calculation for the Reasonable and Customary Charge takes into consideration any unusual circumstances or complications which require additional time, skill or experience in connection with the particular service or procedure. If services are rendered by a PPO Provider, the allowable amount established by the PPO will be considered the Reasonable and Customary Charge.
SEMI-PRIVATE ROOM RATE: The charge made by a Hospital for a room containing two (2) or more beds, including such charges in the intensive care unit.
URGENT CARE FACILITY: A free-standing facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse, and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, a facility located on or in conjunction with or in any way made a part of a regular Hospital shall be excluded from the terms of this definition.

MEDICARE PROVISION

For those Eligible Employees (who have Plan coverage by virtue of their current employment status as defined in Medicare) or spouses of Eligible Employees (who have Plan coverage by virtue of the Eligible Employee's employment status as defined in Medicare), who are age sixty-five (65) or older and who are entitled to benefits under Medicare, this Plan will pay primary benefits, unless the Eligible Employee or spouse refuses coverage under this Plan. If such Eligible Employee or spouse refuses coverage under this Plan, Medicare will be the sole source of benefits. Eligible Employees or spouses of Eligible Employees who have enrolled in this Plan are deemed to have accepted coverage under this Plan until the Plan Administrator receives a written election indicating that an Eligible Employee or spouse of an Eligible Employee refuses coverage under this Plan. Any charges which are not paid under this Plan should be submitted to Medicare as secondary payor. For COBRA Qualified Beneficiaries who are age sixty-five (65) or older and who are entitled to benefits under Medicare, this Plan will pay secondary benefits.

For those Eligible Employees (who have Plan coverage by virtue of their current employment status as defined in Medicare), or Eligible Dependents (who have Plan coverage by virtue of a family member's current employment status as defined in Medicare), who are entitled to benefits under Medicare because of total disability (and who are not or could not be entitled to benefits under Medicare on the basis of End Stage Renal Disease), this Plan will pay primary benefits, unless the Eligible Employee or Eligible Dependent refuses coverage under this Plan. If such Eligible Employee or Eligible Dependent refuses coverage under this Plan, Medicare will be the sole source of benefits. Eligible Employees or Eligible Dependents who have enrolled in this Plan are deemed to have accepted coverage under this Plan until the Plan Administrator receives a written election indicating that an Eligible Employee or Eligible Dependent refuses coverage under this Plan. Any charges which are not paid under this Plan should be submitted to Medicare as secondary payor. For COBRA Qualified Beneficiaries who are entitled to benefits under Medicare because of total disability (and who are not or could not be entitled to benefits under Medicare on the basis of End Stage Renal Disease), this Plan will pay secondary benefits.

For the purpose of this paragraph, the time that a person is an Eligible Employee or Eligible Dependent is added to the time that a person is a COBRA Qualified Beneficiary to determine whether the Plan pays primary benefits or secondary benefits. For those Eligible Employees or Eligible Dependents who are entitled to benefits under Part A of Medicare solely on the basis of End Stage Renal Disease the Plan will pay primary benefits during the 30-month period beginning on the earlier of: the first month in which the Eligible Employee or Eligible Dependent becomes entitled to benefits under Part A of Medicare; or the first month in which the Eligible Employee or Eligible Dependent would have been entitled to benefits under Part A of Medicare if such person had filed an application for such benefits. After the expiration of such 30-month period, Medicare benefits will be primary and this Plan will pay secondary benefits.

For those Eligible Employees or Eligible Dependents who are entitled to benefits under Medicare solely on the basis of End Stage Renal Disease and who subsequently become entitled to benefits under Medicare for the reason of attaining age sixty-five (65) or for a disability other than End Stage Renal Disease, the Plan will pay in accordance with the End Stage Renal Disease provisions stated above.

For those Eligible Employees or Eligible Dependents who are entitled to benefits under Medicare on the basis of attaining age sixty-five (65) or because of disability (other than End Stage Renal Disease), and who subsequently become entitled to benefits under Medicare on the basis of End Stage Renal Disease, the End Stage Renal Disease provisions stated above will apply but only if, prior to such entitlement to benefits under Medicare on the basis of End Stage Renal Disease, the Plan was to pay primary benefits and Medicare was to pay secondary benefits under other provisions of the Plan.

For those Eligible Employees or Eligible Dependents who are not entitled to benefits under Medicare on the basis of attaining age sixty-five (65) or because of disability (other than End Stage Renal Disease), and who become entitled to benefits under Medicare on the basis of attaining age sixty-five (65) or because of disability (other than End Stage Renal Disease) and, simultaneously, End Stage Renal Disease, the End Stage Renal Disease provisions stated above will apply.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent payment of benefits which exceed expenses. It applies when any person who is covered under this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always either pay its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. When any person is eligible for coverage under two (2) or more plans, it is necessary to determine which plan is primary and which plan is secondary. The following rules are used to determine the primary carrier:

1. A plan which does not have a non-duplication of benefits or coordination of benefits provision will be the primary carrier;
2. If all the plans have Coordination of Benefits provisions, a plan is primary if it covers the person as an employee, and secondary if it covers the person as a dependent;
3. The primary plan is the plan that covers the person as an active, full-time employee, or that employee's dependent. The secondary plan is the plan that covers that person in a status other than as an active, full-time employee, or that employee's dependent;
4. If a person is covered as a dependent child under more than one (1) plan:
    a. the plan of the parent whose birthday falls earlier in the year is the primary plan;
    b. if the father and mother have the same birthday, the plan covering the parent longer is the primary plan;
    c. if the other plan's provisions for coordination of benefits does not follow the rule of this plan (as stated in 4a & b), then the rules for coordination of benefits of the other plan shall determine the order of benefits;
    d. if more than one plan covers a person as a dependent child of divorced or separated parents, benefits for the child will be determined by the specific terms of the Court decree. If the Court decree states which parent is responsible for the

health care expenses of the child then that parent's plan shall be primary. If there is no Court decree or the Court decree is silent as to which parent is responsible for the health care expenses of the child, or if the Court decree is not being followed by the parent who is supposed to be providing coverage, then the plan that will pay primary benefits will be determined in the following order:

i. the plan of the parent with custody of the child;
ii. the plan of the spouse of the parent with custody of the child;
iii. the plan of the parent without custody of the child.

5. When the above rules do not establish an order of benefit determination, the benefits of a Plan which has covered the person for the longer period of time shall be determined before the benefits of a Plan which has covered the person the shorter period of time.

This Plan will coordinate benefits with any of the following types of coverage:

1. Group, blanket, franchise or individual insurance coverage;
2. Hospital services payment plans, medical services prepayment plans, health maintenance organizations, or other group prepayment coverage;
3. Any coverage under labor-management trustee plans, union welfare plans, employee organization plans, or employee benefit organization plans;
4. Any coverage provided by automobile "No Fault" legislation or any coverage provided by the Social Security Act or any other statute, including but not limited to Medicare;
5. Any Employer-sponsored non-insured employee benefit plans; and
6. Any coverage for students which is sponsored by, or provided through, a school or other educational institution.

SUBROGATION

By enrolling for coverage under the Plan, Covered Persons understand and agree that if Illness, Injury or other condition to a Covered Person is caused by an act or omission of a third party or the Covered Person, the Plan may, if the requirements of this section are satisfied, advance benefits for medical expenses incurred as a consequence of the act or omission. In addition, Covered Persons agree that if any payments are made to or on behalf of a Covered Person and such payments have arisen as a result of an Injury, Illness or other condition for which the Covered Person has, or may have, or asserts any claim or right of recovery (including, without limitation, claims for pain and suffering, loss of consortium, consequential, punitive, exemplary or other damages) against a third party or parties, then any benefits advanced by this Plan for such medical expenses shall be made on the condition and with the agreement and understanding that the Covered Person shall reimburse the Plan to the extent of (but not exceeding) any amount or amounts recovered by or on behalf of the Covered Person (including the Covered Person's estate) from any third party by way of settlement or in satisfaction of any judgment relating to said claim. For example, should the Plan advance benefits totaling $90,000 on behalf of a Covered Person involved in a subrogation matter, and that Covered Person receive a full and final settlement in the amount of $60,000, the Plan would be entitled to recover the $60,000 amount which, assuming no other source of recovery, would serve to fully satisfy the Plan's subrogation interest in that matter, regardless of any other expenses, such as attorneys' fees or privately paid medical costs which are not covered by Plan provisions. The Plan shall maintain a lien on any such recovery and be entitled to reimbursement in full in accordance with this section, irrespective of whether the settlement monies received by the Covered Person leave a Covered Person fully compensated or "made whole" for all or any of said claims. The Plan shall be entitled to such reimbursement from first dollar recovery amounts received by the Covered Person and as such shall specifically have priority over any other interests including, without limitation, any unpaid medical expenses not submitted through the Plan for any party, attorneys' fees (regardless of whether they are considered contingent or hourly) and legal costs and shall supersede the Covered Person's right to be made whole. As security for the Plan's rights to such reimbursements, the Plan shall be subrogated to all claims, demands, actions or rights of recovery of the Covered Person against any third party or parties (or their insurers) to the extent of any and all benefits advanced by the Plan. The Covered Person agrees to cooperate with and assist the Plan in obtaining or providing any information or document production necessary to support the subrogation rights of the Plan. Any Covered Person who takes any action prejudicing or otherwise impairing the subrogation rights of the Plan shall be liable to the Plan for any losses to the Plan caused by such action, such as withholding information from the Plan regarding third party insurance company's contact information, policy limits or concealing development of any legal proceedings or settlements between legal representatives of Covered Persons and any third parties. Any action prejudicing or otherwise impairing the subrogation rights of the Plan made by the Covered Person shall also terminate the Plan's obligation to advance benefits to or on behalf of the Covered Person. The Plan Supervisor shall withhold payments of claims made under this Plan, to the extent that the Plan Supervisor has reason to believe that said claims arise as a result of any act of a third party, until the Covered Person or the Covered Person's legal representative executes the forms required by the Plan without alteration or modification.

The subrogation rights of the Plan, as set forth in this section, shall also apply to payments made by the Covered Person's own insurance or his own or any auto insurance, including, but not limited to, medical payments coverage, any excess, umbrella, uninsured/underinsured motorists coverage, personal protection policies issued under 'no-fault' coverage provisions, and/or any other applicable insurance coverage (with the exception of payment for property damage).

For purposes of this section and any Agreement executed pursuant hereto, the term Covered Person shall include the dependents, heirs, guardians, executors or other representatives of the Covered Person.

For purposes of this section and any Agreement executed pursuant hereto, the spouses, children and other dependents as Covered Persons under the Plan are third party beneficiaries under the Plan and therefore subject to the same duties and obligations as employees who are Covered Persons under the Plan.

The Plan shall have no obligation to share the cost of, or pay any part of, the Covered Person's attorney fees and costs incurred in obtaining any recovery against the third party.

The Plan retains the right, at its sole discretion, to commence litigation against third parties, file claims or take any other action on behalf of the Covered Person, respective to the Plan's advanced benefits, should the Covered Person not commence litigation, file claims or take appropriate action within a reasonable period of time. Covered Persons must notify the Plan of the Covered Person's claim at the time the Covered Person files a lawsuit to recover damages or 90 days prior to the expiration of the statute of limitations, whichever is sooner. Should the Covered Person fail to comply with the requirements of this section, the Covered Person shall pay the Plan's reasonable collection costs and attorney fees incurred in collecting amounts due under the Plan.

MISCELLANEOUS PROVISIONS

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

The Plan may, without the consent of or notice to any person, release to or obtain from any insurance company or any other party, any information which the Plan deems relevant for the purpose of applying and implementing the terms of the Plan. Any person claiming benefits under the Plan shall furnish to the Plan such information as may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payments that should have been made under this Plan were made by another plan, this Plan shall have the right, exercisable alone and at its sole discretion, to reimburse the other plan in the amount that would have been paid by this Plan. Such reimbursement shall be deemed payment for covered services and the Plan shall be fully discharged from liability.

RIGHTS OF RECOVERY

Whenever payments have been made by the Plan in an amount which exceeds the maximum amount of payment allowed under the Plan at that time, the Plan shall have the right to recover such payment irrespective of to whom paid, to the extent of such excess from among one (1) or more of the following parties: any persons to whom or with respect to whom such payments were made, any insurance companies, or any other organizations or persons.

ARBITRATION

Any controversy or claim arising out of or related to this Plan may be settled by arbitration upon the agreement of each party. Each party shall select an arbitrator and the two arbitrators so chosen shall choose a third arbitrator and the matter in controversy shall be submitted to the three arbitrators. The decision of any two of the three arbitrators shall be final and binding upon the two parties. Each party shall pay the cost of the arbitrator chosen by them and shall each pay one-half of the cost of the third arbitrator.

FRAUDULENT ACTS

A Covered Person who submits incorrect or incomplete notice of claims or proof of loss in an attempt to defraud the Plan will cease to be eligible for Plan benefits hereunder, as of the date the fraudulent information is furnished to the Plan.

DISCRETIONARY AUTHORITY

The Plan Administrator shall have the discretionary power and authority to: determine eligibility for benefits; interpret or construe the terms of the Plan and any other writing affecting the establishment or operation of the Plan; determine questions of fact which arise in connection with the Plan; and decide all matters arising under the Plan, based on the applicable facts and circumstances.

DECLARATORY JUDGMENT

In the event that a question of coverage is presented to a court of competent jurisdiction through a declaratory judgment, and the court rules that the Plan is responsible for providing coverage, then the Plan will cover the expense to the extent permitted by all other Plan provisions.

PLAN MODIFICATION AND AMENDMENT

The Plan Sponsor may modify or amend the Plan from time to time at its sole discretion and the amendments or modifications which affect the Plan Members will be communicated to them. Any Plan amendment shall be by a written instrument signed by a representative or representatives of the company who have been authorized by resolution or other appropriate authority to amend the Carrollton Exempted Village School District Health Benefit Plan and shall become effective as of the date specified in the instrument. A copy of such instrument shall be furnished to the Plan Administrator and any outside provider of Plan administration services.

PLAN TERMINATION

The Plan Sponsor may terminate the Plan at any time. Any termination of the Plan will be communicated to plan members.

ASSIGNMENT OF BENEFITS

In the event a Covered Person has executed an Assignment of Benefits, the Plan shall pay benefits directly to the provider of service. If the Plan receives notification from a provider that the provider has the Covered Person's authorization to assign benefits on file, then that shall be acceptable notice to the Plan that an Assignment of Benefits has been executed.

PROOF OF CLAIMS (Filing of Claims)

Written proof of claims must be furnished to the Plan by or on behalf of the Covered Person or the provider within the earlier of 365 days of the date such claim was incurred, or 90 days of the termination of this Plan (a claim shall be considered incurred on the date the service is rendered or the supply is received). Proof of claims includes the following:

An itemized bill for the service or supply must be furnished to the Plan. An itemized bill for all professional services must include a diagnosis (ICD) code and a CPT (Current Procedural Terminology) code for each service provided.

The Eligible Employee must complete one (1) Employee Statement on a frequency to be determined by the Plan Administrator.

If the Plan Administrator or Plan Supervisor requests information from the Eligible Employee, the Eligible Employee must furnish such information as requested.

If the Plan Administrator or Plan Supervisor requests information from a provider and the provider does not furnish the requested information, the Eligible Employee will be required to obtain the requested information and furnish it to the Plan Administrator or Plan Supervisor.

All of the above requirements must be met within the time period outlined above in order for the claim to be considered.

PAYMENT OF CLAIMS
All Plan benefits are payable to the Eligible Employee, unless the Eligible Employee has assigned such benefits to the provider of services. If the Plan Administrator determines that any Eligible Employee entitled to Plan Benefits is incompetent, the Plan Administrator may cause all Plan benefits thereafter becoming due to such Eligible Employee to be made to any other person for his benefit, without the responsibility to follow the application of amounts so paid. Any benefits otherwise payable to an Eligible Employee following the date of death of such Eligible Employee shall be paid to his or her spouse, or, if there is no surviving spouse, to his or her estate. Payments made pursuant to this section shall completely discharge the Plan and the Plan Administrator.

APPEAL PROCEDURES
If a claim is denied in whole or in part, the Plan Supervisor will provide written notification to the Eligible Employee in the same fashion as reimbursement for a claim. A claim worksheet will be provided by the Plan Supervisor, showing the calculation of the total amount payable, charges not payable, and the reason. If additional information is needed for payment of a claim, the Plan Supervisor will request such information. If a claim is denied in whole or in part, the Eligible Employee may appeal the decision. The Eligible Employee or his authorized representative may examine pertinent documents (except for information in the file, which the Physician does not wish made known to the claimant), and the Eligible Employee may send a written letter of appeal outlining his position. The written appeal must be filed with the Plan Supervisor within sixty (60) days after denial is received; however, it is suggested that it be filed promptly whenever possible. Upon receipt of the written appeal, the Plan Supervisor will furnish copies of all relevant documents to the Plan Administrator for review and final decision. A decision will be made within sixty (60) days unless special circumstances require extension, in which case such decision will be rendered no later than 120 days. A letter will be sent to the Eligible Employee (or his authorized representative) which references the pertinent Plan provisions supporting the decision. This decision will be final.

ACTIONS
No action at law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor shall such action be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

CONFORMITY OF LAW
If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

CHANGE IN PLAN PROVISIONS
Any change in Plan provisions will apply only to expenses incurred on or after the effective date of the Plan change. If, on the effective date of a Plan change, a Covered Person is confined in a Hospital, the Plan provisions in force before the effective date of the change will continue in force until, in the case of the Eligible Employee, the Eligible Employee returns to work for one full day, or, in the case of an Eligible Dependent, the Eligible Dependent is released from the Hospital.

PLAN IS NOT A CONTRACT
The Plan shall not be deemed to constitute a contract between the Plan Sponsor and any Employee or to be a consideration for, or an inducement or condition of, the employment of an Employee. Nothing in the Plan shall be deemed to give an Employee the right to be retained in the service of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the Plan Sponsor with the bargaining representatives of any Employee.

BOOKLETS
The Plan Sponsor has issued herewith to each covered employee under this Plan an individual booklet which summarizes the benefits to which the person may be entitled, to whom benefits may be payable, and the provisions of the Plan principally affecting the Employee and his dependents. The booklet is intended to satisfy the requirement for a Summary Plan Description as specified in ERISA.

FORM OF WORDS
A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the content clearly indicates otherwise.

EXAMINATION
The Plan Administrator, at the Plan's expense, shall have the right and opportunity to have the Covered Person examined whose Injury or Illness is the basis of a claim hereunder when and so often as it may reasonably require during the pendency of claim hereunder. If the Plan requires that the Covered Person be examined by a Physician of the Plan's choice, and the Covered Person does not comply with this request, the Plan has the right to deny benefits for the claim in question. The Plan Administrator also has the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

WORKERS' COMPENSATION NOT AFFECTED
This Plan is not in lieu of, and does not affect any requirement for coverage by Workers' Compensation Insurance.

MEDICAL CHILD SUPPORT ORDERS
The Plan will follow the applicable state requirements, if any, for orders issued by: (1) a court of competent jurisdiction, or (2) through an administrative process established under state law that has the force and effect of law under applicable state law, that establishes a parent's obligation to provide health coverage to children who are Eligible Dependents and who are the subject(s) of such order, provided such order does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan.

MEDICAID PROVISION
Payments for benefits will be made in accordance with any assignment of rights made by or on behalf of a Covered Person as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of such Act as in effect on August 10, 1993. The fact that an Eligible Employee or Eligible Dependent is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act will not be taken

into account for determining eligibility or determining or providing benefits under this Plan. To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act and this Plan would provide a benefit for those items or services constituting such assistance, payment for benefits under this Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to the Covered Person to such payment for such items or services.

INDEPENDENT REVIEW PROVISIONS

Ohio Superintendent of Insurance Review of Plan Coverage

In the event that a Covered Person has been denied coverage of a health care service on the grounds that the service is not a service covered under the terms of the Plan, and the Covered Person has exhausted the Plan's appeal procedures, and the Covered Person has submitted a written request to the Ohio Superintendent of Insurance to review the denial, and the Ohio Superintendent of Insurance notifies the Plan that the service is a service covered under the terms of the Plan, then the Plan will cover such service.

If the Ohio Superintendent of Insurance notifies the Plan that making the determination requires the resolution of a medical issue, the Covered Person may request an external review of the denial in accordance with the "External Review of Medical Necessity" provision below or the "External Review for Terminal Illness" provision below.

External Review of Medical Necessity

An external review of medical necessity shall mean a review conducted in accordance with applicable law by an independent review organization assigned by the Ohio Superintendent of Insurance. A Covered Person (or the Covered Person's parent, guardian, or other person authorized to act on behalf of the Covered Person with respect to health care decisions) may request an external review of medical necessity provided:

1. the request is in writing;
2. the Plan has denied, reduced, or terminated coverage for what would be a covered health care service except that the Plan has determined that the health care service is not Medically Necessary;
3. the proposed service, plus any ancillary services and follow-up care, will cost the Covered Person more than $500 if the proposed service is not covered by the Plan; and
4. the request is accompanied by written certification from the Covered Person's provider or the health care facility rendering the health care service to the Covered Person that the proposed service, plus any ancillary services and follow-up care, will cost the Covered Person more than $500 if the proposed service is not covered by the Plan.

A Covered Person need not be afforded an External Review of Medical Necessity if:

1. the Ohio Superintendent of Insurance has determined that the health care service is not a service covered under the terms of the Plan pursuant to the Ohio Superintendent of Insurance Review of Plan Coverage provision above;
2. the Covered Person has failed to exhaust the appeal procedures of the Plan; or
3. the Covered Person has previously been afforded an external review of medical necessity for the same denial of coverage and no new clinical information has been submitted to the Plan.

The Plan may deny a request for an external review of medical necessity if the request is made later than sixty (60) days after receipt by the Covered Person of notice from the Ohio Superintendent of Insurance pursuant to the Ohio Superintendent of Insurance Review of Plan Coverage provision above, that making a determination on the denied, reduced or terminated coverage for the health care service requires the resolution of a medical issue. An external review of medical necessity may also be requested by the Covered Person's provider or the health care facility rendering health care services to the Covered Person provided the provider or health care facility obtains the prior consent of the Covered Person and satisfies the other requirements for making the request. In the event that a Covered Person's provider certifies that the Covered Person's condition could, in the absence of immediate medical attention result in:

1. placing the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or the unborn child, in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part,

the Covered Person may request an expedited external review of medical necessity.

If an expedited external review of medical necessity is permitted, the Covered Person does not have to provide evidence that the proposed service, plus any ancillary services and follow-up care, will cost the Covered Person more than $500 if the proposed service is not covered by the Plan or the written certification from the Covered Person's provider or the health care facility rendering the health care service to the Covered Person that the proposed service, plus any ancillary services and follow-up care, will cost the Covered Person more than $500 if the proposed service is not covered by the Plan. An expedited external review of medical necessity may be requested orally or by electronic means provided that written confirmation of the request is submitted to the Plan not later than five (5) days after the request is made.

The Plan will provide any coverage determined by the independent review organization's decision to be Medically Necessary, subject to the other terms, limitations, and conditions of the Plan. The cost of the external review of medical necessity shall be paid by the Plan.

External Review for Terminal Illness

An external review for terminal Illness shall mean a review conducted in accordance with applicable law by an independent review organization assigned by the Ohio Superintendent of Insurance.

A Covered Person may request an external review for terminal Illness provided:

1. the request is in writing;
2. the Covered Person has a terminal condition that, according to the current diagnosis of the Covered Person's Physician, has a high probability of causing death within two (2) years;

3. the Covered Person requests a review not later than sixty (60) days after receipt by the Covered Person of notice from the Ohio Superintendent of Insurance pursuant to the Ohio Superintendent of Insurance Review of Plan Coverage provision above, that making a determination requires the resolution of a medical issue;
4. the Covered Person's Physician certifies that the Covered Person has a terminal condition that, according to the current diagnosis of the Covered Person's Physician, has a high probability of causing death within two (2) years and any one of the following is applicable:
   a. standard therapies have not been effective in improving the condition of the Covered Person;
   b. standard therapies are not medically appropriate for the Covered Person; or
   c. there is no standard therapy covered by the Plan that is more beneficial than the therapy described in provision 5. below;
5. the Covered Person's Physician has recommended a drug, device, procedure, or other therapy that the Physician certifies, in writing, is likely to be more beneficial to the Covered Person, in the Physician's opinion, than standard therapies, or the Covered Person has requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition;
6. the Covered Person has been denied coverage by the Plan for a drug, device, procedure, or other therapy, recommended or requested pursuant to provision 5. above and has exhausted the Plan's Appeal Procedures; and
7. the drug, device, procedure, or other therapy, for which coverage has been denied, would be covered under the Plan except for the Plan's determination that the drug, device, procedure, or other therapy is Experimental/Investigational.

In the event that a Covered Person's Physician determines that a therapy would be significantly less effective if not promptly initiated, an expedited external review for terminal Illness may be requested. A request for an expedited external review for terminal Illness may be made orally or by electronic means provided that written confirmation of the request is submitted to the Plan not later than five (5) days after the request is made. The Covered Person's provider must certify that the requested or recommended therapy would be less effective if not promptly initiated.

The opinion of the majority of the experts on the panel selected by the independent review board will be binding on the Plan with respect to the Covered Person. If the opinions of the experts on the panel are evenly divided as to whether the therapy should be covered, the Plan will provide such coverage. The cost of the external review for terminal Illness shall be paid by the Plan.

If the Plan's initial denial of coverage for a therapy recommended or requested pursuant to provision 4. above is based upon an external review for terminal Illness of that therapy that meets the requirements of the applicable Ohio law for external reviews of a therapy for a terminal condition, a second external review of the therapy will not be required.

How to Request an Expedited Review of Medical Necessity

Written requests for an expedited review of medical necessity and written confirmation of oral or electronic requests for an expedited review of medical necessity should be addressed as follows and sent to:

EXPEDITED REVIEW OF MEDICAL NECESSITY
Carrollton Exempted Village School District
c/o Medillume III, Inc.
1444 Hamilton Ave.
Cleveland, OH 44114

Oral requests for an expedited review of medical necessity should be made by calling:
(216) 575-5370 or (800) 919-3311.

Electronic requests for an expedited review of medical necessity should be addressed and sent as follows:
For fax transmissions:

EXPEDITED REVIEW OF MEDICAL NECESSITY
Carrollton Exempted Village School District
c/o Medillume III, Inc.
Via Fax Transmission
and fax to (216) 566-0171

How to Request an Expedited Review for Terminal Illness

Written requests for an expedited review for terminal Illness and written confirmation of oral or electronic requests for an expedited review for terminal Illness should be addressed as follows and sent to:

EXPEDITED REVIEW FOR TERMINAL ILLNESS
Carrollton Exempted Village School District
c/o Medillume III, Inc.
1444 Hamilton Ave.
Cleveland, OH 44114

Oral requests for an expedited review for terminal Illness should be made by calling:
(216) 575-5370 or (800) 919-3311.

Electronic requests for an expedited review for terminal Illness should be addressed and sent as follows:
For fax transmissions:

EXPEDITED REVIEW FOR TERMINAL ILLNESS
Carrollton Exempted Village School District
c/o Medillume III, Inc.
Via Fax Transmission
and fax to (216) 566-0171

PROHIBITION OF RESCISSION OF COVERAGE

This Plan shall not rescind coverage for individuals who are covered under the plan, except in cases where the individual has engaged in fraud or made an intentional misrepresentation of material fact, as prohibited by the terms of the Plan and with advance

notice. The term Rescission shall mean a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuation of coverage is *not* a rescission if the cancellation or discontinuance of coverage has only a prospective effect; or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. The Plan must provide at least 30 days' advance written notice to each participant who would be affected before coverage may be rescinded.

EXTERNAL AND INTERNAL APPEAL PROCESS

Request for external review. A claimant can file a request for an external review generally within four months after receiving a notice of an adverse benefit determination or a final internal adverse benefit determination.

Preliminary review. Within five business days after receiving the external review request, the Plan must complete a preliminary review of the request to determine whether the claimant was covered under the Plan at the time the health care expense was requested or, in the case of a retrospective review, was covered under the plan at the time the health care service was provided; the adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the eligibility requirements under the terms of the plan; the claimant has exhausted the plan's internal appeal process, if required to do so; and 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 must issue a written notification to the claimant. If the request is complete but not eligible for external review, the notification must include the reasons for ineligibility and contact information for the DOL's Employee Benefits Security Administration. If the request is not complete, the written notification must describe the information needed to complete the request, and the claimant must be permitted to perfect the request within the four-month filing period or within 48 hours after receiving the notification, whichever is later.

Referral to independent review organization. The Plan must assign an independent review organization (IRO) that is accredited by the Utilization Review Accreditation Committee (URAC) or by a similar nationally recognized accrediting organization, to conduct the external review. The IRO will make a final decision within 45 days. The decision of the IRO is binding on the Plan. In order to prevent against bias and ensure independence, the plan must contract with at least three (3) IROs for assignments under the Plan and rotate claim assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection).

Reversal of plan's decision. Upon receipt of a notice of a final external review decision that reverses the adverse benefit determination or final internal adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review for Self-Insured Group Health Plans

Request for expedited review. The Plan must permit a claimant to make a request for an expedited external review if the claimant receives an adverse benefit determination (or a final internal adverse benefit determination) that involves a medical condition of the claimant for which the time frame for completion of an expedited internal appeal (or a standard external review in the case of a final internal adverse benefit determination) would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function. In addition, the Plan must permit a claimant to make a request for an expedited external review if the claimant receives a final internal adverse benefit determination that 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.

Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan must conduct a preliminary review and provide written notification, abiding by the same preliminary review and written notification requirements that apply to standard external reviews (as described above).

Referral to independent review organization. The Plan must assign the claim to an IRO, if it is determined that the request is eligible for external review, abiding by the same assignment requirements that apply to standard external reviews (as described above). The assigned IRO, to the extent the information or documents are available and the IRO considers them 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 conclusions reached during the plan's internal claims and appeals process.

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

HOW TO FILE A CLAIM

* For medical claims, simply present your Plan identification card to the provider of service, and ask your provider to send the bill to the address shown on the ID card. Provider bills must include the appropriate diagnosis and procedure code information. If you are submitting bills instead of your provider, make sure you provide the following written information: the Employer's name, the Eligible Employee's name, and the Eligible Employee's member ID number.
* For dental claims, a completed dental claim form or an itemized bill from the Dentist's office will be accepted. If using a dental claim form, please complete Parts I and IV of the form and have your Dentist complete Parts II, III and V, then mail the completed form to the address printed on the form.
* Proof of claims must be submitted to Self-Funded Plans, Inc. within the time frame specified in the Proof of Claims provision outlined in this summary plan description.

HOW TO APPEAL A CLAIM

If your claim is denied in whole or in part, you will receive written notification delivered in the same fashion as reimbursement for a claim. A claim worksheet will be provided by the Plan Supervisor, showing the calculation of the total amount payable, charges not payable, and the reason. If additional information is needed for payment of a claim, the Plan Supervisor will request same.
If a claim is denied in part or in full, you may appeal the decision. You or your authorized representative may examine pertinent documents (except for information in the file which the Physician does not wish made known to the claimant), and you may send a written letter of appeal outlining your position. The written appeal must be filed with the Plan Supervisor within 180 days after denial is received; however, it is suggested that it be filed promptly whenever possible.
Upon receipt of the written appeal, the Plan Supervisor will furnish copies of all relevant documents to the Plan Administrator for review and final decision.
A decision will be made within sixty (60) days unless special circumstances require extension, in which case such decision will be rendered no later than 120 days. A letter will be sent to you which references the pertinent Plan provisions supporting the decision. Unless the "Independent Review Provisions" apply, this decision will be final.

GENERAL INFORMATION

1. **NAME OF PLAN:** The Carrollton Exempted Village School District Health Benefit Plan
2. **NAME & ADDRESS OF PLAN SPONSOR:**
   Carrollton Exempted Village School District
   252 Third St NE
   Carrollton, Ohio 44615-1236

   Jefferson Health Plan
   Jefferson County Board of Education
   2023 Sunset Boulevard
   Steubenville, Ohio 43952
3. **EFFECTIVE DATE OF PLAN:**. The plan was originally effective on October 1, 1983. This document reflects amended and restated benefits which are effective January 1, 2015.
4. **EMPLOYER IDENTIFICATION NUMBER:** 34-6000522
5. **PLAN NUMBER:** 501
6. **ACCOUNT NUMBER:** 506-775
7. **TYPE OF PLAN:** This is a welfare plan providing medical, prescription drug and dental benefits.
8. **TYPE OF ADMINISTRATION:** Certain administrative services are provided by a contract administrator retained by the Employer. Self-Funded Plans, Inc., which is not an insurance company, is the contract administrator.
9. **NAME, BUSINESS ADDRESS & TELEPHONE NUMBER OF THE PLAN ADMINISTRATOR:**
   Carrollton Exempted Village School District
   252 Third St NE
   Carrollton, Ohio 44615-1236
   (330) 627-2181
10. **NAME OF THE DESIGNATED AGENT FOR SERVICE OF LEGAL PROCESS & ADDRESS AT WHICH PROCESS MAY BE SERVED ON SUCH AGENT:** Same as above
11. **FINANCING OF BENEFITS:** Employee contributions, if any, are based on the terms of the applicable collective bargaining agreement.
12. **THE DATE OF THE END OF THE YEAR FOR THE PURPOSES OF MAINTAINING THE PLAN'S FISCAL RECORDS:** Plan year ending May 31st of each year.
13. **NON-GRANDFATHERED PLAN:** This Plan is a non-grandfathered health plan under the Patient Protection and Affordable Care Act (the Affordable Care Act).