CRESTLINE EXEMPTED VILLAGE SCHOOL DISTRICT

MEDICAL, PRESCRIPTION DRUG AND DENTAL BENEFITS PLAN

SCHEDULE OF MEDICAL BENEFITS

BENEFITS	PPO	NON-PPO
RETAIL PRESCRIPTION DRUG BENEFIT (up to a 30-day supply) **Co-Pay Per Prescription** (if Brand is purchased & Generic is available, Covered Person pays Brand co-pay plus difference in cost between Generic and Brand)	100% after co-pay per prescription, filled or refilled $10 Generic $20 Brand Preferred $40 Brand Non-Preferred	
MAIL ORDER DRUG BENEFIT (up to a 90-day supply) **Co-Pay Per Prescription** (if Brand is purchased & Generic is available, Covered Person pays Brand co-pay plus difference in cost between Generic and Brand)	100% after co-pay per prescription, filled or refilled **MANDATORY – DESCRIBED HEREIN** $20 Generic $40 Brand Preferred $80 Brand Non-Preferred	
CALENDAR YEAR DEDUCTIBLE (the PPO and non-PPO deductible shall not be applied toward each other)	$300 per person $600 per family	$500 per person $1,000 per family
BENEFIT PERCENTAGE PAYABLE (unless shown as different percentage)	80%	60%
COINSURANCE MAXIMUM OUT-OF-POCKET AMT PER CALENDAR YEAR (the PPO and non-PPO coinsurance out-of-pocket amts shall not be applied toward each other)	$600 per person $1,200 per family	$1,200 per person $2,400 per family
OFFICE VISIT (Illness/Injury)	100% after $15 co-pay	60% after deductible
PREVENTATIVE SERVICES Routine Physical Exam (age 9 & older; 1/cal yr) Well Child Care (max of $500 from birth to age 1 and max of $150/birth year age 1 to 9) Child immunizations Routine mammogram (max ben of 130% of the lowest Medicare reimb rate in Ohio – 1/cal yr) Routine pap (one per calendar year) Routine chest x-ray, CBC, EKG, comprehensive metabolic panel & urinalysis (age 9 and older; one each per calendar year)	 100% after $15 co-pay 100% after $15 co-pay 100%, deductible waived 80% after deductible 80% after deductible 80% after deductible	 60% after deductible 60% after deductible 60% after deductible 60% after deductible 60% after deductible 60% after deductible
OUTPATIENT PHYSICAL THERAPY (max of 40 visits/cal yr)	80% after deductible	60% after deductible
OUTPATIENT SPEECH THERAPY (max of 20 visits/cal yr)	80% after deductible	60% after deductible
CHIROPRACTIC (max of 12 visits/cal year)	80% after deductible	60% after deductible
EMERGENCY ROOM (Emergency Care) (includes facility, ancillary and ER Physician – co-pay applies to facility only)	100% after $100 co-pay (co-pay waived if admitted)	
EMERGENCY ROOM (Non-Emergency Care)	80% after $100 co-pay (waived if admitted)	60% after $100 co-pay (waived if admitted)
HOSPICE (max $3,000/cal yr)	80% after deductible	60% after deductible
TMJ (max $1,000/lifetime)	80% after deductible	60% after deductible
SKILLED NURSING FACILITY (120 day max/cal yr)	80% after deductible	60% after deductible
HOME HEALTH CARE (max 100 visits/cal yr)	80% after deductible	60% after deductible
LIFETIME MAXIMUM BENEFIT	$2,000,000 (will not apply to Essential Health Benefits)	

Benefits that require a co-pay are not subject to the deductible.

PRE-ADMISSION NOTIFICATION IS REQUIRED FOR ALL NON-EMERGENCY HOSPITAL ADMISSIONS. POST-ADMISSION NOTIFICATION IS REQUIRED FOR ALL EMERGENCY HOSPITAL ADMISSIONS.

Annual dollar limits that are currently in the Plan will be changed to $2,000,000 for the period July 1, 2013 through June 30, 2014 Effective July 1, 2014, annual dollar limits shall be eliminated for Essential Health Benefits.

SCHEDULE OF DENTAL BENEFITS

CALENDAR YEAR DEDUCTIBLE	
ROUTINE PREVENTIVE & ORTHODONTIC SERVICES	NONE
ESSENTIAL AND COMPLEX SERVICES COMBINED	$50 PER PERSON $100 PER FAMILY
BENEFIT PERCENTAGES	
ROUTINE PREVENTIVE SERVICES	100% OF REASONABLE CHARGE
ESSENTIAL SERVICES	80% OF REASONABLE CHARGE
COMPLEX SERVICES	60% OF REASONABLE CHARGE
ORTHODONTIC SERVICES	75% OF REASONABLE CHARGE
MAXIMUM BENEFIT PAYABLE PER CALENDAR YEAR	
ROUTINE PREVENT., ESSENTIAL & COMPLEX SVS COMBINED	$2,500
MAXIMUM LIFETIME BENEFIT	
ORTHODONTIC SERVICES	$1,200

MEDICAL EXPENSE BENEFITS

PRE-ADMISSION/POST-ADMISSION NOTIFICATION PROGRAM

Your 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 you use a non-PPO provider and do not follow this Program, you may be responsible for non-covered charges. Instructions for using this program are as follows:

Non-Emergency Hospital Admission. Calls for non-emergency hospital admissions should be made as soon as it is known that the Covered Person needs to be admitted.

Emergency Hospital Admission. If the Covered Person is admitted to the Hospital on an Emergency basis, the call must be made by the next business day following the date of admission.

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.

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.

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 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. The payment rates vary between PPO Providers and non-PPO Providers, as described on the Schedule of Medical Benefits. Since PPO Providers have agreed to negotiated rates, Covered Persons will not be billed for amounts over the Reasonable and Customary Charge if they use PPO Providers.

Services provided by non-PPO providers will be payable at the non-PPO level of benefits, unless one or more of the following conditions apply:

1. If the Covered Person uses a Physician who is a PPO Provider and a Hospital that is a PPO Provider for a given procedure, any 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.
2. If the Plan Administrator determines that certain covered services can only be provided by a non-PPO provider, the Plan Administrator may authorize such services to be performed by the non-PPO provider and payable at the PPO level of benefits. Such authorization will be in writing.
3. If the Covered Person requires Emergency Care, the PPO level of benefits will apply until the Covered Person's condition has sufficiently stabilized so that transfer to a PPO provider for any required continued treatment is reasonably possible.

RETAIL PRESCRIPTION DRUG BENEFIT

The Prescription Drug Benefit covers Medically Necessary drugs which may be lawfully dispensed only upon the written prescription of a Physician. Most diabetic supplies and injectable insulin are also covered. Insulin needles and syringes are covered when dispensed with and included on the same prescription as injectable insulin. This benefit includes coverage for multiple sclerosis drugs and vitamins that require a prescription.

Each Covered Person will receive a prescription drug identification card. When a Covered Person presents the card to a member pharmacy, he need only pay the pharmacist the amount shown as the co-pay in the Schedule of Medical Benefits for any prescription, filled or refilled.
If a Physician prescribes a drug that is on either the Brand Preferred list or the Brand Non-Preferred list, and a Generic Drug is available, and the Covered Person chooses the Brand drug, then the Covered Person must pay the co-pay for the Brand

Preferred or Brand Non-Preferred drug (whichever is applicable) plus the difference in cost between the Brand Preferred or Brand Non-Preferred drug (whichever is applicable) and the Generic Drug.

If the Covered Person is not in possession of his identification 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 Caremark. If this is the case, the employee will submit drug expenses on a medical claim form and be reimbursed by the Plan for eligible prescription drug expenses at the rate of 100%, after the prescription drug co-payment, per prescription (filled or refilled), has been satisfied.

The following charges are excluded under this benefit: ADD and narcolepsy drugs for Covered Persons age 19 and older; anabolic steroids; antihyperglycemics (injectable); anti-obesity agents; blood or blood plasma; contraceptives; cosmetic drugs (such as anti-wrinkle agents, hair growth stimulants and hair removal products); DESI drugs; Differin, Tazorac, Tretinoin (Retina-A, Altinac, Avita and Ziana), Accutane, Amnesteem, Claravis and Sotret for Covered Persons age 19 and older; fertility drugs; growth hormones; hematinics and hemostatics; immunization agents; impotency drugs; insulin pens, insulin for inhalation and inhalation delivery devices; insulin pumps and pump supplies; pigmenting/depigmenting agents; smoking deterrent or cessation aids; 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 DRUG BENEFIT

The Mail Order Drug Benefit will be administered by Caremark Mail Service Pharmacy. This benefit covers a ninety (90) day supply of many maintenance medications, subject to the co-payment per prescription that is specified in the Schedule of Medical Benefits. The drugs that are excluded in the Prescription Drug Benefit are also excluded in the Mail Order Drug Benefit. **If a maintenance prescription is available through the mail order pharmacy and the Covered Person chooses not to use the mail order pharmacy, the Covered Person will be required to pay two times the appropriate co-pay when the prescription is refilled beyond the third time within a 180 day period.**

BENEFIT PERCENTAGE PAYABLE/COINSURANCE MAXIMUM OUT-OF-POCKET AMOUNT

Eligible Expenses are payable at the percentage rates shown in the Schedule of Medical Benefits. Once the Coinsurance Maximum Out-of-Pocket Amount shown in the Schedule of Medical Benefits is reached, then Eligible Expenses will be payable at 100% for the balance of that calendar year. The Coinsurance Maximum Out-of-Pocket Amount includes only coinsurance paid by the Covered Person. It does not include deductibles, co-pays, penalties, or charges that are excluded or that exceed limits outlined in this Plan.

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.

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

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.

Eligible Expenses
The following services and supplies are eligible expenses under this Plan (benefit percentage payable and maximum benefit limitations are specified in the Schedule of 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. Educational, vocational and training services are covered while an Inpatient. Two (2) days of Partial Confinement in a Hospital will be considered as one (1) day of confinement.

2. Physicians' charges for treatment of an Illness or Injury (including charges for an elective sterilization and elective abortion). For surgery claims, 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. The Office Visit (Illness/Injury) benefit described in the Schedule of Medical Benefits applies only to the actual office visit and does not include other services. The Office Visits benefit does not apply to charges for chiropractic care.
3. Charges for the following immunizations: hepatitis B; human papillomavirus vaccine (HPV); influenza; MMR; meningococcal vaccine; pneumococcal polysaccharide; rabies vaccine; tetanus toxoid,and varicella (VSV). For children under age 9, such services are payable as "Child immunizations" specified on the Schedule of Medical Benefits. For ages 9 and above, such services are subject to the applicable deductible and coinsurance.
4. Charges for the Preventative Services that are specified in the Schedule of Medical Benefits.
5. Charges for orthotic devices, including braces for the leg, arm, neck or back; trusses; and back and special surgical corsets. Non-covered devices include but are not limited to garter belts, arch supports, corsets and corn and bunion pads; corrective shoes, except with accompanying orthopedic braces; and arch supports and other foot care or foot support devices only to improve comfort or appearance. These include but are not limited to care for flat feet and subluxations, corns, bunions, calluses and toenails.
6. 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 Drug Benefit).
7. Charges for the services of a registered professional nurse (R.N.), licensed vocational nurse (L.V.N.) and licensed practical nurse (L.P.N.) other than a nurse who ordinarily resides in the Covered Person's home, or is a Close Relative.
8. Charges for anesthesia and the administration thereof.
9. Charges for diagnostic x-ray and laboratory examinations.
10. Charges for allergy testing and treatments.
11. Charges for chemotherapy and x-ray, radium and radioactive isotope therapy.
12. Charges for physical therapy prescribed by the attending Physician as to type and duration when performed by a licensed physical therapist. Benefits are limited as specified in the Schedule of Medical Benefits. No benefits are provided once a patient can no longer significantly improve from treatment for the current condition.
13. Charges for occupational therapy prescribed by the attending Physician as to type and duration when performed by a licensed occupational therapist or physical therapist. Charges incurred for supplies used in connection with occupational therapy are not covered. Occupational therapy is covered if it is expected that the therapy will result in a significant improvement in the level of functioning and that improvement will occur within 60 days of the first treatment.
14. Charges for professional ambulance service when used in emergency situations to transport a Covered Person from a home, scene of accidental Injury or medical Emergency to a Hospital; between Hospitals; between a Hospital and Skilled Nursing Facility; from a Hospital or Skilled Nursing Facility to the Covered Person's home, or from a Physician's office to a Hospital. 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. No other charges for transportation or travel will be covered.
15. Charges for care rendered in an Ambulatory Surgical Center.
16. Charges for blood and blood plasma, to the extent it is not donated or otherwise replaced, and the cost of administration, donation and blood processing of the Covered Person's own blood in anticipation of surgery.
17. Charges for the purchase, fitting, adjustments, repairs and replacements of prosthetic devices that are artificial substitutes and necessary supplies that replace all or part of a missing body organ or limb and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body organ or limb. Non-covered appliances include but are not limited to: dentures, unless as a necessary part of a covered prosthesis; dental appliances; eyeglasses, including lenses or frames, unless used to replace an absent lens of the eye; replacement of cataract lenses unless needed because of a lens prescription change; taxes included in the purchase of a covered prosthetic appliance; deluxe prosthetics that are specially designed for uses such as sporting events; and wigs and hair pieces.
18. Charges for medical and surgical supplies which serve a specific therapeutic purpose, including syringes, needles, oxygen, surgical dressings and other similar items. Items usually stocked in the home for general use are not covered. These include but are not limited to elastic bandages, thermometers, corn and bunion pads, jobst stockings and support/compression stockings.
19. 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. Covered Durable Medical Equipment includes blood glucose monitors; respirators; home dialysis equipment; wheelchairs; hospital beds; crutches; and mastectomy bras. Repair costs are covered if they do not exceed the rental price of another unit for the estimated period of use, or if they do not exceed the purchase price of a new unit.
20. Charges for care in a Skilled Nursing Facility if a Physician determines that the Covered Person requires skilled nursing care. Charges for room and board (at the Semi-Private Room Rate) and necessary services and supplies will be covered for up the maximum period specified in the Schedule of Medical Benefits. Educational, vocational and training services are covered while an Inpatient.
21. 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 learning impairment, 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. Benefits are limited as specified in the Schedule of Medical Benefits.

22. Charges for home care visits rendered through a Home Health Care Agency, limited as specified in the Schedule of Medical Benefits. 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. 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.
23. Charges for services and supplies furnished in connection with transplant procedures that are not Experimental or Investigational. Such transplants include bone marrow, cornea, heart, heart/lung, kidneys, liver, lung, pancreas, and pancreas/kidney transplants. Additional organ/tissue transplants will be covered if Medically Necessary, not Experimental or Investigational and considered acceptable medical practice for the Covered Person’s condition. The following conditions apply:
    a. 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 recipient.
    b. if both the donor and the recipient are covered under this Plan, eligible medical expenses incurred by each person will be considered as the recipient’s charge.
    c. 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 a covered expense.
24. 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; and bereavement counseling for 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.
25. Charges for maternity. Covered charges include obstetrical services, prenatal and postnatal care. 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. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six [96] hours as applicable). If an Employee has dependent coverage, the Plan covers Hospital and Physician charges for Medically Necessary and/or routine care for the newborn well baby while the baby is in the Hospital. The Plan also covers charges for the baby's circumcision. When a decision is made to discharge a mother or newborn prior to the expiration of the applicable number of hours of Inpatient care required to be covered, at home post delivery follow-up care visits are covered at the Covered Person’s residence by a Physician or nurse when performed no later than 72 hours following the mother’s and newborn’s discharge from the Hospital. Coverage for this visit includes, but is not limited to parent education, physical assessments; assessment of the home support system; assistance and training in breast or bottle feeding; and performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening. At the mother’s discretion, this visit may occur at the facility of the provider.
26. Charges for care rendered in an Alcoholism Treatment Facility (payable as if such charges were incurred in a Hospital).
27. Charges for care rendered in an Urgent Care Facility.
28. Charges for inhalation/respiratory or pulmonary therapy.
29. Charges for a cardiac rehabilitation program that is Medically Necessary as a result of a cardiac event.
30. Charges for the following when a Covered Person is receiving benefits in connection with a mastectomy and elects breast reconstruction in connection with such mastectomy: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; treatment of physical complications of all stages of mastectomy, including lymphedemas; and prostheses and mastectomy bras.

31. 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. Dialysis performed to treat drug addiction will be subject to the limits (if any) outlined in the Plan for such drug addiction treatment.
32. Charges for hyperbaric therapy provided by a Hospital.
33. Charges for treatment of jaw joint problems, including temporomandibular joint dysfunction (TMJ) syndrome and conditions of structures linking the jaw bone and skull and the complex of muscles, nerves, and other tissues related to that joint. Covered services include, but are not limited to: orthopedic (not orthodontic) appliances and physical therapy. Such coverage is limited as specified in the Schedule of Medical Benefits.
34. This Plan shall be in compliance with the Federal Mental Health Parity and Addiction Equity Act and any amendments thereto. Benefits for treatment of mental health/drug abuse/alcoholism shall be payable on the same basis and at the same benefit percentage as any physical Illness. Any benefit limits applicable to such treatment shall be removed.

MAXIMUM BENEFIT

The Maximum Lifetime Benefit payable per person is specified in the Schedule of Medical Benefits. The Maximum Lifetime Benefit applies only to charges incurred while the person is covered under this Plan.

PRE-EXISTING CONDITION LIMITATION

A Pre-Existing Condition is any Injury or medical condition for which medical advice, diagnosis, care, and/or treatment was recommended to or received by a Covered Person during the six (6) month period ending on the Enrollment Date. In the event of a Pre-Existing Condition, benefits will not be payable for the Pre-Existing Condition until a period of nine months has elapsed following the Enrollment Date. If a Covered Person had Creditable Coverage and did not have a Significant Break in Coverage, the Creditable Coverage will be credited toward the nine month exclusion. The Pre-Existing Condition Limitation will not apply to a newborn or newly adopted child (under age 18) who is enrolled for coverage within thirty (30) days of birth or placement for adoption (or who has Creditable Coverage from birth, adoption or placement for adoption without a Significant Break in Coverage). The Pre-Existing Condition Limitation will not apply to pregnancy. The Pre-Existing Condition Limitation shall not apply to Covered Persons who are younger than age 19. Effective July 1, 2014, the Pre-Existing Condition Limitation shall not apply to any Covered Persons.

MEDICAL PLAN LIMITATIONS AND EXCLUSIONS

The following charges are limited or excluded under the Plan:
1. Charges for Experimental or Investigational procedures.
2. 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.
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 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.
6. Charges which were incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.
7. Charges for services which are not Medically Necessary (except as specified herein) or which have not been recommended or prescribed by a Physician or performed by or under the direction of a Physician.
8. Charges for occupational accidents or Illnesses, or charges that are also eligible expenses covered by Workers' Compensation.
9. 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. Cosmetic surgery following weight loss or weight loss surgery is not covered.
10. Charges for tattoo removal.
11. Charges for dietary and/or nutritional guidance or training, except as specified.
12. Charges for educational, vocational or training purposes, except as specified.
13. Charges for treatment of conditions related to an autistic disease of childhood, developmental delay, learning disabilities, behavioral problems or mental retardation.
14. 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.
15. Charges for weight loss drugs, for treatment of weight loss by methods such as dietary supplements and any care which is primarily dieting or exercise for weight loss; or charges for weight loss surgery, including complications related to this surgery, unless the Covered Person's weight is at least twice the ideal amount and is Medically Necessary as determined by the Plan.
16. Charges for marital counseling.

17. Charges to treat inorganic sexual inadequacies or dysfunctions, or for sex transformation and hormones related to such treatment and charges for related psychiatric care.
18. Charges for contraceptives.
19. Charges for the reversal of an elective sterilization.
20. Charges for 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; or fertility drugs.
21. Charges for dental care (including charges for dental implants). An exception to this exclusion will be provided for treatment rendered as a result of an accidental Injury or for the surgical removal of bony impacted teeth. In addition, if it is Medically Necessary that a Covered Person be treated at a Hospital for a dental condition, the Hospital charges will be a covered expense.
22. Charges for personal hygiene and convenience items.
23. Charges incurred in connection with eye refractions, 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.
24. Charges for massage therapy, hypnotism, or acupuncture, whether or not administered by a Physician.
25. Charges for after-hours care.
26. Charges for telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
27. Charges for fraudulent or misrepresented claims.
28. Charges for outpatient blood storage services.
29. Charges for prescription drugs (including the prescription drug co-pays) that are covered under the Retail Prescription Drug Benefit or Mail Order Drug Benefit.
30. Charges for any services or supplies incurred in connection with treatment of nicotine addiction.
31. Charges for personal services not required in the diagnosis or treatment of an Illness or Injury.
32. Charges for Custodial Care.
33. Charges which are in excess of the Reasonable and Customary Charge.
34. Charges for Preventive/Maintenance Care, routine physical examinations, and immunizations (except as specified herein).
35. 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.
36. Charges for services which are not performed according to accepted standards of medical practice for the condition being treated or which are not performed within the scope of the provider's license.
37. Charges received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
38. Charges for physical examinations or services required by an insurance company to obtain insurance; physical examinations or services required by a governmental agency such as the FAA and DOT; physical examinations or services required by an employer in order to begin or to continue working; premarital examinations; screening examinations, except as specified; or x-ray examinations made without film.
39. Charges for which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This applies when the Covered Person is eligible for Medicare even if the Covered Person did not apply for or claim Medicare benefits. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of benefits.
40. Charges for topical anesthetics.
41. Charges for minor nonoperative endoscopic procedures which include, but are not limited to, anoscopy.
42. Charges for water aerobics.
43. Charges for residential care rendered by a Residential Treatment Facility.
44. Charges for treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.
45. Charges for over-the-counter drugs, vitamins or herbal remedies.
46. Charges for specialized camps.
47. Charges for a particular health service in the event that a non-PPO provider waived co-payments, non-PPO coinsurance and/or the non-PPO deductible, no benefits are provided for the health service for which the non-PPO co-payments, coinsurance and/or deductible are waived.
48. Charges for non-covered services or services specifically excluded in this Plan.

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 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 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 which the Employee is required to pay 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; and are necessary for the treatment of a non-occupational disease or a non-occupational Injury and are customarily employed nationwide for the treatment of the dental condition; taking into account the current total oral condition of the covered family member.

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.

Routine and Preventive Services
1. Initial and periodic oral evaluations, limited to two evaluations in any calendar year.
2. Bitewing x-rays (limited to two sets per calendar year) and other diagnostic x-rays other than full-mouth panoramic x-rays
3. Prophylaxes, limited to two prophylaxes in any calendar year.
4. Space maintainers, but only if the covered family member has not yet attained the age of 19 years.
5. Topical fluoride applications, but not more than one treatment in any calendar year for Eligible Dependent children under the age of 19.
6. Emergency palliative treatment, including emergency oral evaluations.
7. Dental sealants, limited to one every 36 months.

Essential Services
1. Full mouth/panoramic x-rays, limited to one set in any period of 36 consecutive months.
2. Consultations and other evaluations by a dental specialist.
3. Amalgam or resin based composite fillings.
4. Endodontic services.
5. Periodontic services.
6. Extractions, including simple and surgical extractions and impactions.
7. Repairs, relines and adjustments of prosthetics (complete and partial dentures, crowns, fixed partial dentures [bridges]). Relining and rebasing of dentures is covered if done no less than six months after initial placement but not more than once in any 36 month period.
8. General anesthesia and IV sedation for a covered oral or dental surgery.
9. Minor oral surgery, including alveoloplasty and vestibuloplasty (excluding any charges which are covered under the medical benefits plan).
10. Drug injections.
11. Stainless Steel Crowns.

Complex Services
1. Inlays, onlays and crowns, limited to one every five years per tooth.
2. Complete dentures, fixed partial partial dentures (bridges) and removal partial dentures, limited to one every five years per unit. One replacement of a temporary denture is allowed if a permanent denture is installed within 12 months of the installment of the temporary denture.
3. Temporomandibular (TMJ) services (excluding any charges which are covered under the medical benefits plan).

Orthodontic Services

The term Orthodontic Procedure means the use of active appliances to move teeth, to correct faulty position of teeth (malposition); or abnormal bite (malocclusion). 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. A charge is an eligible charge if all these conditions are met:

1. It is made for a service or supply furnished in connection with an orthodontic procedure and before the end of the estimated duration shown in the Orthodontic Treatment Plan;
2. The orthodontic procedure is needed to correct one of these conditions: vertical or horizontal overlap of upper teeth over lower teeth (overbite or overjet) of at least four (4) millimeters; faulty alignment (either frontwards or backwards) of the upper and lower arches with each other by at least the width of one (1) tooth section (one [1] cusp); or cross-bite.

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 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.
2. If a Covered Person changes dental providers during a course of treatment, or if more than one dental provider treats the Covered Person for a procedure, additional benefits are not provided.
3. 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.
4. Charges for dental care which does not meet the standards of dental practice accepted by the American Dental Association.
5. 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.
6. Charges for telephone consultations, online consultations, missed appointments, the completion of claims forms, or copies of medical records.
7. Charges for the repair or replacement of a damaged, lost or stolen space maintainer.
8. Charges for dental implants.
9. Charges for personalized restorations, specialized techniques in constructing dentures or partial fixed dentures or replacement of appliances that can be made serviceable.
10. Charges for oral hygiene and dietary instruction and plaque control programs.
11. Charges for dental care arising out of or in the course of employment for pay or profit or which is covered by Workers' Compensation or a similar law.
12. 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.
13. Charges incurred in 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.
14. Charges for dental care resulting from any Injury sustained as a result of war, declared or undeclared, or resulting from a riot, an act of civil disobedience, nuclear explosion, or nuclear accident.
15. Charges, if any, that are included as covered medical expenses.
16. Charges made by a Dentist or Dental Hygienist who normally lives in the Covered Person's home, or is a Close Relative.
17. Charges which were incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

This Plan shall be in compliance with the School Employee Health Care Board (SEHCB) Dependent Eligibility Audit Rules. 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.

New Eligible Employees who are enrolled will be covered on the date they become Eligible Employees. If an Eligible Employee 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, and a new Pre-Existing Condition Limitation will not apply to such Eligible Employees or their Eligible Dependents.

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. A newborn of an Eligible Employee must be properly enrolled into the Plan within thirty (30) days from the date of birth. A spouse will be considered an Eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a dependent of the Eligible Employee within thirty (30) days of the date of marriage. If a dependent is acquired other than at the time of his birth, due to a court order, decree, or marriage, that dependent will be considered an Eligible Dependent of the Eligible Employee from the date of such court order, decree, or marriage, provided this new dependent is properly enrolled as a dependent of the Eligible Employee within thirty (30) days of the court order, decree, or marriage. 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. For the purpose of this paragraph, the term "Placed" or "Placement" shall mean the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's Placement terminates upon the termination of such legal obligation. If an Eligible Dependent 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 credit will be given toward maximums, deductible, etc.

An Eligible Dependent who loses Eligible Dependent status because he is no longer a Full-Time Student may have coverage reinstated upon becoming a Full-Time Student and meeting all other requirements of an Eligible Dependent. Such Eligible Dependent's coverage will be reinstated on the date that such Eligible Dependent is once again a Full-Time Student.

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 June of any year) and coverage will be effective on the next following July 1st. If Late Enrollees are determined to have a Pre-Existing Condition, the Pre-Existing Condition Limitation provision of this Plan will apply.

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 the Eligible Employee declined coverage and stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment;
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 the Eligible Employee declined coverage and stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment;
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 the Eligible Employee declined coverage and stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment;

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. Proof of Special Enrollee status is required. Coverage for such Special Enrollees will be effective as follows:

i. 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.
ii. 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.

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 date of termination of employment (any extended benefits based on sick leave, etc. will be followed based on the negotiated agreement in effect at the time of the leave).
3. The date all coverage or certain benefits are terminated on a particular class by modification of the Plan.
4. The date the Eligible 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.

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). Eligible Employees 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 they return from the leave. In addition, such persons will continue to be covered under the Plan as if there had been no break in service, and a new Pre-Existing Condition Limitation will not apply to such persons as long as the condition was covered prior to the approved leave.

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). The COBRA provision in this Plan shall be modified to be in compliance with any changes made to 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 Eligible Employee must become ineligible for group coverage because of a Qualifying Event consisting of a termination of the Eligible 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 Eligible 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. 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 (other than for gross misconduct) 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 COBRA department at the Plan Supervisor 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, following the procedures outlined in the section entitled "Notification of Qualifying Event."

   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 (other than for gross misconduct) 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 COBRA Department at the Plan Supervisor 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.

CONVERSION FOLLOWING CONTINUATION. The Plan will make available to the Covered Person the option of enrolling in the medical conversion coverage available under the group health plan. In order for the conversion to be effective, application for the medical conversion coverage must be received by the insurance company during the time period designated by the insurer, and the first payment of the premium, as designated by the insurance company, must accompany the application.

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 either (1) obtain a Record Change Form from the Employer and submit the completed Record Change Form to the **Treasurer** within the time period noted in this paragraph; or (2) send either a Record Change Form or written documentation of the event to the Plan Supervisor, including 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 Plan Supervisor or 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.

TRADE ADJUSTMENT ASSISTANCE OR ALTERNATIVE TRADE-ADJUSTMENT ASSISTANCE. Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an Eligible Employee or former Eligible Employee becomes eligible for TAA or ATAA, but only if the election is made within the six months immediately after the individual's group health plan coverage ended. Employees or former employees who believe they qualify or may qualify for TAA or ATAA should contact the Employer promptly after qualifying for TAA or ATAA.

FMLA PROVISION. 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 (other than because of gross misconduct) 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 COBRA department 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 TREATMENT FACILITY: A part of a Hospital devoted primarily to alcoholism treatment or a facility primarily established for alcoholism 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.
ASSIGNMENT OF BENEFITS: Authorization by the Eligible Employee for the Plan Supervisor to pay benefits directly to the provider of the service.
BRAND PREFERRED DRUG: A non-Generic Drug that is included on the Caremark preferred drug list ("Formulary Drug") for the most commonly prescribed drug categories.
BRAND NON-PREFERRED DRUG: A non-Generic Drug that is not included on the Caremark preferred drug list ("Formulary Drug") for the most commonly prescribed drug categories.
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.
COSMETIC SURGERY: Surgery performed for the purpose of improving appearance rather than for restoring bodily function.
COVERED PERSON: The Eligible Employee or any person who is defined in this Plan as an Eligible Dependent of the Eligible Employee and is covered for benefits under this Plan.
CREDITABLE COVERAGE: Coverage of an Eligible Employee or Eligible Dependent under any of the following:

1. A group health plan that is an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.
2. Health insurance coverage that consists of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.
3. Part A or B of Title XVIII of the Social Security Act (Medicare).
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).
5. Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, uniformed services means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service Act).
6. A medical care program of the Indian Health Service of a tribal organization.
7. A State health benefits risk pool. For purposes of this section, a State health benefits risk pool means a) an organization qualifying under section 501 (c)(26) of the Internal Revenue Code; b) a qualified high risk pool described in section 2744(c)(2) of the Public Health Services Act, or c) any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health insurance coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition 1) are unable to acquire medical care coverage for such condition through insurance or from an HMO or 2) are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.
8. A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).
9. A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance coverage to individuals who are enrolled in the plan.
10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504[e]).

Coverage under items 1-10 above will not be taken into account if there has been a Significant Break in Coverage.
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: it is able to withstand repeated use; it is primarily and customarily used to serve a medical purpose; and it is not generally useful to a person in the absence of Illness or Injury.

ELIGIBLE DEPENDENTS <u>for medical and prescription drug benefits only:</u> The Eligible Employee's spouse (which means one that is recognized as a spouse under the Internal Revenue Code), and all children from birth to twenty-six (26) years of age. The term "children" will include only (1) natural children; (2) legally adopted children (including children Placed with the adopting parents during the period before the adoption becomes final); (3) stepchildren; and (4) children for whom either the Eligible Employee or his spouse is the legal guardian or custodian or any children who, by court order, must be provided health care coverage by the Eligible Employee or his spouse. 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; however, prior to January 1, 2014, if they are eligible to receive benefits under an employer sponsored health plan (other than a group health plan sponsored by the employer of either parent), they will not be eligible for this coverage (on or after January 1, 2014, they will be eligible for this coverage). 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 twenty-six (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. To enroll children for this coverage, the parent should request the appropriate enrollment materials from the Employer. In order for a child to be covered under these provisions, the Eligible Employee must also be enrolled for coverage. Children who meet the criteria will be treated as Special Enrollees.

In compliance with the Ohio House Bill 1 and any amendments thereto, 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 or medical conversion coverage. If there are any changes to this law, this Plan will automatically be amended to be in compliance.

ELIGIBLE DEPENDENTS (for dental benefits only): The Eligible Employee's spouse (which means one that is recognized as a spouse under the Internal Revenue Code), and all unmarried children from birth to twenty-three (23) years of age. The term "children" will include only (1) natural children; (2) legally adopted children (including children Placed with the adopting parents during the period before the adoption becomes final); (3) stepchildren; and (4) children for whom either the Eligible Employee or his spouse is the legal guardian or custodian or any children who, by court order, must be provided health care coverage by the Eligible Employee or his spouse. To be considered Eligible Dependents, children must receive over half of their support during the calendar year from the Eligible Employee unless coverage is being provided under court order.

In addition to the above, children will be considered as Eligible Dependents from age twenty-three (23) to age twenty-five (25) if they are unmarried, Full-Time Students and meet the other requirements in the preceding paragraph. It is the Eligible Employee's responsibility to provide the Plan Supervisor with proof of Full-Time Student status (from the school) for each semester. The Eligible Employee must notify the Employer when the Eligible Dependent is no longer a Full-Time Student. A child who is physically or mentally incapable of self-support upon attaining the age of twenty-three (23) may be considered an Eligible Dependent while remaining incapacitated, unmarried and continuously covered under the Plan. Proof of this incapacity must be furnished within thirty-one (31) days after coverage would have otherwise terminated. 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, nor any dependent child who is married. Also, if both parents are employed by the Employer, children will be covered only as Eligible Dependents of one parent.

ELIGIBLE EMPLOYEES: All employees who meet the criteria outlined in the Agreement between the Crestline Exempted Village School District and OAPSE or the Agreement between the Crestline Board of Education and The Crestline Education Association, whichever is applicable, are eligible to be covered by the Plan. Also, any other full-time employees who are not part of either bargaining unit and who work a minimum of 224 days per contract year and an equivalent of 40

hours per week are eligible to be covered by the Plan. Also, certificated employees working for the Crestline Cares Program 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;
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 Crestline Exempted Village School District.

ENROLLMENT DATE: The first day of coverage under the Plan.

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:

1. Any treatments, services, supplies or related expenses that are educational or provided primarily for research; or
2. 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.

FULL-TIME STUDENT: A Eligible Dependent child who is enrolled in and regularly attending an accredited college or university for the minimum number of credit hours required by that college or university in order to maintain Full-Time Student status. A child will continue to be a Full-Time Student during periods of regular vacation established by the institution. If the person does not continue as a Full-Time Student immediately following the period of vacation, the Full-Time Student designation will end on the last day of the school term that was attended on a full-time basis.

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 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.

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 independent social worker will be considered as a Physician.

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 Crestline Exempted Village School District Medical, Prescription Drug, and Dental Benefits 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 and supplies 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 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.
RESIDENTIAL TREATMENT FACILITY: A facility that provides care on a 24 hour a day, 7 days a week, live-in basis for the evaluation and treatment of residents with psychiatric or chemical dependency disorders for residents who do not require care in an acute or more intensive medical setting.
SECURITY INCIDENTS: This term has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.
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.
SIGNIFICANT BREAK IN COVERAGE: A period of sixty-three (63) consecutive days during all of which the individual does not have any Creditable Coverage, except that neither a Waiting Period nor an affiliation period is taken into account in determining a Significant Break in Coverage.
SKILLED NURSING 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.
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 or spouses of Eligible Employees (who have Plan coverage by virtue of the Eligible Employee's current 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 or Eligible Dependents 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), Medicare benefits will be primary and this Plan will pay secondary benefits. 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), 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.

When this Plan's benefits are secondary, benefits will be paid as secondary as described under the Coordination of Benefit Provision.

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. Only the amount paid by the Plan will be charged against the Plan maximums. 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. Ohio 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 (neither laid off nor retired), 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 benefit order will be determined in accordance with the Ohio Department of Insurance rule on coordination of benefits.
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

If any payments are made to or on behalf of a Covered Person and such payments arise 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 payments made by the 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 claims. The Plan shall be entitled to reimbursement in full in accordance with this paragraph irrespective of whether the Covered Person has been fully compensated for all or any of said claims. 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 payments made by the Plan; and any Covered Person that 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 causes by such action. 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 make payments to or on behalf of the Covered Person. Each Covered Person agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action the Plan Administrator may require to facilitate enforcement of its rights. The Plan shall withhold payments of claims made under this Plan, to the extent that the Plan has reason to believe that said claims arise as a result of any act of a third party, until the Covered Person or Covered Person's legal representative executes a subrogation agreement. The subrogation rights of the Plan as set forth in these paragraphs also apply to payments made by the Covered Person's own

auto insurance (with the exception of payment for property damage). For purposes of these paragraphs and any subrogation agreement executed pursuant hereto, the term Covered Person shall include heirs, guardians, executors or other representatives of the Covered Person.

MISCELLANEOUS PROVISIONS

MEDICAL BENEFIT CONVERSION

An individual health policy is available for an Eligible Employee and/or his Eligible Dependents, under age sixty-five (65), whose coverage under this Plan ceases due to termination of employment, change in marital status or loss of eligibility. The benefits provided under the new policy and the individuals to be covered will be determined by the rules of the insurer at the time the conversion application is received by the insurer. No evidence of insurability will be required. Written application and the first premium must be paid within thirty-one (31) days after the termination of group coverage. Information as to the coverage available and premium rates can be obtained at the time coverage terminates.

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.

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 Employer who have been authorized by resolution or other appropriate authority to amend the 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 twelve (12) months after the date such claims are incurred (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 code (ICD 9 CM) and a CPT code (Current Procedural Terminology) for each service provided. The bill should be sent to the address shown on the ID card.

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 twelve (12) month time period 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 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 letter will be sent to the Eligible Employee (or his authorized representative) which references the pertinent Plan provisions supporting the decision. Unless the "Independent Review Provisions" apply, 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.

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.

CLAIM DETERMINATIONS

Claim determinations will be made within thirty (30) days of the date a claim is filed. A claim will be considered "filed" when it is received by the Plan Supervisor after being accurately repriced by the PPO. If the claim is incomplete thirty days after the claim has been filed, a fifteen day extension is allowed if the Plan Administrator determines that it will still be unable to make the decision.

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 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; serious impairment to bodily functions; or 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
Crestline 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
Crestline 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
Crestline 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) 377-7233.

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

For fax transmissions:

EXPEDITED REVIEW FOR TERMINAL ILLNESS
Crestline Exempted Village School District
c/o Medillume III, Inc. 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.

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 social security 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.

GENERAL INFORMATION

1. **NAME OF PLAN:** The Crestline Exempted Village School District Medical, Prescription Drug and Dental Benefits Plan
2. **NAME, ADDRESS & PHONE NUMBER OF PLAN SPONSOR/PLAN ADMINISTRATOR:**

   Crestline Exempted Village Schools
   P. O. Box 350
   Crestline, Ohio 44827
   (419) 683-3647

   Jefferson Health Plan
   Jefferson County Bd of Education
   2023 Sunset Boulevard
   Steubenville, Ohio 43952
3. **NAME OF THE DESIGNATED AGENT FOR SERVICE OF LEGAL PROCESS & ADDRESS AT WHICH PROCESS MAY BE SERVED ON SUCH AGENT:** Same as above
4. **EFFECTIVE DATE OF PLAN:** January 1, 2008
5. **EMPLOYER IDENTIFICATION NUMBER:** 34-6400349
6. **PLAN NUMBER:** 501
7. **ACCOUNT NUMBER:** 506-824
8. **TYPE OF PLAN:** This is a group health plan providing medical, prescription drug and dental benefits.
9. **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.
10. **FINANCING OF BENEFITS:** The Employer allows employees to contribute to the cost of employee and dependent coverage through enrollment in an IRS Section 125 cafeteria plan using salary reduction agreements.
11. **THE DATE OF THE END OF THE YEAR FOR THE PURPOSES OF MAINTAINING THE PLAN'S FISCAL RECORDS:** Plan year ending June 30th of each year.
12. **GRANDFATHERED STATUS:** This Plan believes that it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act (for example, the elimination of lifetime limits on benefits). Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator outlined in the plan document and summary plan description. Participants may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.