

2/18/09: Received signed acceptance of rewritten Plan Document

COSHOCTON COUNTY COMMISSIONERS
EMPLOYEE HEALTH & WELFARE PLAN
PLAN DOCUMENT

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PLAN SPECIFICATIONS

Employer	Coshocton County Commissioners
Plan Administrator, Plan Sponsor and Named Fiduciary	Coshocton County Commissioners 401 ½ Main Street Coshocton, Ohio 43812-1586 Phone: (740) 622-1158
Agent for Legal Service	Coshocton County Commissioners
Plan	Coshocton County Commissioners Employee Health & Welfare Plan
Type of Plan	Self-Funded Medical, Dental and Prescription Plan
Administration	Self-Administered by the Employer: The Employer has appointed a Third Party Administrator to handle the day to day operation of the Plan.
Third Party Administrator	Aultra Administrative Group 4845 Fulton Drive, NW P.O. Box 35276 Canton, Ohio 44735-5276 Phone: (330) 493-7278
Funding	Self-funded with Employer and Employee Contributions <u>Employer Contributions</u> The Employer makes contributions, as needed, to pay benefits from its general assets and purchase reinsurance as reimbursement for catastrophic claims <u>Employee Contributions</u> Established as required, from time to time, by the Employer
Plan Participants	Employees of Coshocton County Commissioners as defined herein
Original Self-funded Effective Date	January 1, 2001
Effective Date Plan was Rewritten in Entirety	January 1 , 2009
Plan Year	January 1 st - December 31 st
Group Number	K00005
Employer Identification Number	31-6400064
Plan Number	501

SCHEDULE OF DENTAL BENEFITS

Covered dental expenses will include expenses incurred for dental services listed in this Dental Schedule of Benefits. The Plan may agree to accept, as covered dental expenses, expenses for services not listed. To be considered, services should be identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature and/or by description and submitted to the Plan.

The Plan will determine the maximum covered expense for services that it accepts. The maximum covered expense so determined will be consistent with the maximums listed.

For the purpose of this Plan, any Class I or II dental service provided for in this schedule will be considered a Class IV dental service when performed for or in connection with orthodontic treatment.

MAXIMUM BENEFIT

Maximum Calendar Year Benefit per Person for Class I, II, and III Services Combined	\$1,000
Maximum Lifetime Benefit per Person for Orthodontia (for Covered Dependents up to age 19)	\$1,000

DEDUCTIBLE AMOUNTS

Preventive Services (Class I)	None
Basic Services (Class II) and Major Services (Class III):	
Each Person, Each Calendar Year	\$25
Maximum per Family per Calendar Year	\$50
Orthodontia Care (Class IV) per Lifetime (each Person)	\$50

COINSURANCE

Subject to Reasonable and Customary Fees

Preventive Services & Emergency Treatment	100%
Basic Services	80%
Major Services	80%
Orthodontia Care (Six months waiting period, for Covered Dependents up to age 19)	50%

SCHEDULE OF MEDICAL BENEFITS

BENEFITS MAY BE LIMITED FOR PRE-EXISTING CONDITIONS. PLEASE SEE THE SECTION ENTITLED "PRE-EXISTING CONDITIONS" FOR FURTHER INFORMATION.

THE BENEFITS SHOWN IN THIS SCHEDULE FOR HOSPITALIZATIONS AND SURGERIES MAY BE REDUCED IF A PERSON DOES NOT CONTACT AULTRA ADMINISTRATIVE GROUP AS SPECIFIED UNDER THE PLAN. PLEASE SEE THE SECTION ENTITLED "COST CONTAINMENT" FOR FURTHER INFORMATION.

COMBINED NETWORK AND NON-NETWORK MAXIMUMS

Individual Lifetime Maximum for ALL Benefits	\$1,000,000
Individual Lifetime Maximum Benefit for Alcohol and/or Drug Abuse (Inpatient & Outpatient combined)	\$12,500

DEDUCTIBLE AMOUNTS EACH CALENDAR YEAR

Updated 10/1/2009

NETWORK DEDUCTIBLE AMOUNTS EACH CALENDAR YEAR:

Each Person.....	\$200 \$400
Each Family.....	\$400 \$800

(Example: 3 family members each have Network expenses of \$190, \$110 and \$100 during a Calendar Year for a total of \$400. No further Network deductible is then required for any other Family member during the Calendar Year.)

NON-NETWORK DEDUCTIBLE AMOUNTS EACH CALENDAR YEAR:

Updated 10/1/2009

Each Person.....	\$750 \$1000
Each Family.....	\$1,000 \$2000

(Example: 3 family members each have Non-Network expenses of \$550, \$250 and \$200 during a Calendar Year for a total of \$1,000. No further deductible is then required for any other Family member during the Calendar Year.)

NETWORK AND NON-NETWORK DEDUCTIBLES EACH CALENDAR YEAR: When *BOTH* Network and Non-Network providers are utilized by a Covered Person during any Calendar Year, the expenses applied to the Network Calendar Year Deductible will not apply toward the satisfaction of the Non-Network Calendar Year Deductible; expenses applied to the Non-Network Calendar Year Deductible will not apply toward the satisfaction of the Network Calendar Year Deductible.

Amounts a person must pay for the following expenses *will not* count towards satisfaction of the Calendar Year Deductible:

1. Expenses which are not eligible under the Plan; or
2. Reductions in Covered charges which must be paid by a Covered Person due to failure to pre-certify a Hospital admission or In-patient surgery; or
3. All Copays.

NETWORK PHYSICIAN OFFICE COPAY

Each time a Network Physician charges for an office visit, it is subject to an Office Visit Copay. This is the amount that must be paid by the Covered Person before any benefits are payable by the Plan. Limited to one Copay per provider per day.

Copay for Physician's charge for an Office Visit.....\$10.00 unless otherwise stated

Network Physician Office Visit Copays do not apply toward the satisfaction of Individual or Family Out-of-Pocket Maximum.

COINSURANCE (PERCENTAGE PAID)

EXCEPT WHERE OTHERWISE SHOWN, EXCLUDED OR LIMITED, ALL BENEFITS WILL BE PAID ON A REASONABLE & CUSTOMARY BASIS AT THE FOLLOWING PERCENTAGE LEVELS:

	<u>NETWORK</u>	<u>NON-NETWORK</u>
Coinsurance Each Calendar Year per Individual:	85%/15% to \$5,333; 100% Thereafter	70%/30% to \$4,167; 100% Thereafter
Coinsurance Each Calendar Year per Family:	85%/15% to \$10,666; 100% Thereafter	70%/30% to \$8,334; 100% Thereafter
Maximum Individual Out-of-Pocket Expense (INCLUDES the Deductible):	\$1,000	\$2,000
Maximum Family Out-of-Pocket Expense (INCLUDES the Deductible):	\$2,000	\$4,000

When *BOTH* Network and Non-Network providers are utilized by a Covered Person during any Calendar Year, the Network Out-of-Pocket Expenses will not apply toward the satisfaction of the Non-Network Out-of-Pocket Maximum and the Non-Network Out-of-Pocket Expenses will not apply toward the satisfaction of the Network Out-of-Pocket Maximum.

Amounts a person must pay for the following expenses *will not* count towards the satisfaction of the Out-of-Pocket Maximum:

1. Expenses which are not eligible under the Plan; or
2. Outpatient treatment of Non-Biologically based Mental and/or Nervous Disorders; or
3. Outpatient treatment of Alcohol and/or Drug Abuse; or
4. Reductions in Covered charges which must be paid by a Covered Person due to failure to pre-certify a Hospital admission or In-patient surgery; or
5. All Copays.

The benefits provided and percentage paid under the Plan will depend on whether services are received from a Network Provider or a Non-Network Provider. A list of the Network Providers can be obtained from the Plan Administrator free of charge.

BASIC BENEFITS

(Paid at 100% Network and Non-Network; Deductible Waived; Copay Waived)

	<i>NETWORK PROVIDER</i>	<i>NON-NETWORK PROVIDER</i>
<i>SECOND SURGICAL OPINION (& Third, if necessary)</i>	100%	100%
Copay Applies	No	No
Deductible Applies	No	No

This benefit includes Diagnostic Tests prior to an Inpatient surgery.

BASIC BENEFITS (cont.)
(Paid at 100% Network and Non-Network; Deductible Waived; Copay Waived)

ROUTINE PHYSICALS
(Age 9 years old and older)

	100%	100%
Copay Applies	No	No
Deductible Applies	No	No

Calendar Year Maximum..... Up to \$200

Eligible charges for Routine Physicals include, the Physician's office visit charge and related tests, x-rays, routine cancer screenings, routine prostate exam, and lab work.

Charges for Routine Physicals, which exceed the Calendar Year maximum, are not covered.

ROUTINE GYNECOLOGICAL EXAM AND PAP
(Employee & Spouse Only)

	100%	100%
Copay Applies	No	No
Deductible Applies	No	No

Limited to one per Calendar Year.

ROUTINE MAMMOGRAM
(Employee & Spouse Only)

	100%	100%
Copay Applies	No	No
Deductible Applies	No	No

Limited to one per Calendar Year.

ROUTINE EYE EXAM

	100%	100%
Copay Applies	No	No
Deductible Applies	No	No

Limited to \$35 payable per visit and further limited to one exam every two (2) Calendar Years.

ROUTINE HEARING EXAM

	100%	100%
Copay Applies	No	No
Deductible Applies	No	No

Limited to \$35 payable per visit and further limited to one exam every two (2) Calendar Years. Hearing Aids are not covered.

MAJOR MEDICAL BENEFITS

NETWORK BENEFIT

NON-NETWORK BENEFIT

WELL CHILD CARE

(Newborn up to Age 9 years old)

	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes

Calendar Year Maximum..... 10 Visits

Eligible charges for Well Child Care include, the Physician's office visit charge and related tests and lab work.

MAJOR MEDICAL BENEFITS (cont.)

	<u>NETWORK BENEFIT</u>	<u>NON-NETWORK BENEFIT</u>
IMMUNIZATIONS		
(Newborn up to Age 9 years old)	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes
The Human Papillomavirus Vaccine and Meningococcal Vaccine are covered up to age 25 years old.		
PHYSICIAN'S CHARGES FOR OFFICE VISIT	100%	70%
Copay Applies	Yes \$10	No
Deductible Applies	No	Yes
Copay applies to the office visit charge only and does not apply to other services received during the office visit.		
PHYSICIAN'S CHARGES FOR SERVICES PROVIDED AT THE OFFICE	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes
ALL OTHER PHYSICIAN CHARGES	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes
SURGERY		
(Office, Outpatient & Inpatient)	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes
INPATIENT HOSPITAL CHARGES	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes
MEDICAL EMERGENCY CARE IN A HOSPITAL EMERGENCY ROOM (Life Threatening)	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes
NON-MEDICAL EMERGENCY CARE IN A HOSPITAL EMERGENCY ROOM	50%	50%
Copay Applies	No	No
Deductible Applies	Yes	Yes
URGENT CARE FACILITY		
Approved	100%	70%
Copay Applies	Yes \$50	No
Deductible Applies	No	Yes
Non-Approved	85%	70%
Copay Applies	Yes \$50	No
Deductible Applies	Yes	Yes
HOSPICE CARE	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes

MAJOR MEDICAL BENEFITS (cont.)

	<u>NETWORK BENEFIT</u>	<u>NON-NETWORK BENEFIT</u>
HOME HEALTH CARE	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes

Calendar Year Maximum.....Up to 40 Visits

Each visit by a home health aide of up to four consecutive hours in a 24-hour period will be considered as one Home Health Care visit.

SKILLED NURSING FACILITY	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes

Benefit Maximum.....Up to 120 Days in per convalescent period.

Please refer to the section entitled "Description of Medical Benefits" for information concerning the additional requirements, which must be satisfied in order for these expenses to be eligible under the Plan.

DIAGNOSTIC SERVICES/ X-RAY & LAB	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes

ALLERGY SERVICES	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes

Eligible charges for Allergy Services include, allergy testing, allergy extract and allergy treatment. Allergy testing is limited to a 40 test maximum.

CHARGES MADE BY A LICENSED MASSOTHERAPIST	50%	50%
Copay Applies	No	No
Deductible Applies	No	No

Calendar Year Maximum.....Up to 12 Visits

CHARGES MADE BY A CHIROPRACTOR	50%	50%
Copay Applies	Yes \$10	No
Deductible Applies	No	Yes

Calendar Year Maximum..... Up to \$250

Covered charges include those made by a chiropractor for office visits, treatments and related x-rays.

CHARGES MADE BY A PODIATRIST		
Office Visit	100%	70%
Copay Applies	Yes \$10	No
Deductible Applies	No	Yes
Diagnostic Testing, Surgery And other services	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes

MAJOR MEDICAL BENEFITS (cont.)

	<u>NETWORK BENEFIT</u>	<u>NON-NETWORK BENEFIT</u>
AMBULANCE CHARGES	85%	85%
Copay Applies	No	No
Deductible Applies	Yes	Yes (Network Deductible)

Ambulance services in most instances do not have a Network, therefore benefit will be paid at the Network level.

THERAPY SERVICES	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes

Regardless of place of service, therapy services include eligible charges for Speech Therapy, Occupational Therapy, Rehabilitation Services, Physical Therapy, Respiratory Therapy and Cardiac Rehab I & II (III not covered).

BIRTH CONTROL	85%	85%
Copay Applies	No	No
Deductible Applies	No	No

Generic birth control pills only and Depo-Provera.

ALL OTHER COVERED CHARGES	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes

INPATIENT TREATMENT OF <u>NON-BIOLOGICALLY BASED</u> MENTAL AND/OR NERVOUS DISORDERS AND ALCOHOL/ SUBSTANCE ABUSE	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes

Calendar Year Maximum.....Up to 30 Days

If a person is partially confined, two days of partial confinement will be considered as one day of confinement. "*Partial confinement*" means treatment for at least 3 hours but no more than 12 hours in any 24-hour period.

OUTPATIENT TREATMENT OF <u>NON-BIOLOGICALLY BASED</u> MENTAL AND/OR NERVOUS DISORDERS AND ALCOHOL/ SUBSTANCE ABUSE	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes

Calendar Year Maximum.....Up to 30 Visits

Limited to one visit/treatment session per day. The word "visit" as used here is deemed to include each attendance of the Physician to the patient, regardless of the type of professional services rendered during such attendance, whether it might be otherwise termed a consultation, a treatment, or given some other name.

MAJOR MEDICAL BENEFITS (cont.)

	<u>NETWORK BENEFIT</u>	<u>NON-NETWORK BENEFIT</u>
TREATMENT OF <u>BIOLOGICALLY BASED</u> MENTAL AND/OR NERVOUS DISORDERS		
Office	100%	70%
Copay Applies	Yes \$10	No
Deductible Applies	No	Yes
Outpatient/Inpatient	85%	70%
Copay Applies	No	No
Deductible Applies	Yes	Yes

ADDITIONAL PROVISIONS RELATING TO TREATMENT OF MENTAL AND/OR NERVOUS CONDITIONS AND ALCOHOL AND/OR DRUG ABUSE

Outpatient benefits for the treatment of Alcohol and/or Drug Abuse are subject to a Lifetime Maximum as shown in the Schedule of Benefits. In addition, eligible expenses in connection with the Outpatient treatment of Non-Biologically Based Mental and/or Nervous Disorders and Alcohol and/or Drug Abuse will not count towards the satisfaction of your Out-of-Pocket Maximum (will never be paid at 100%).

EXCEPTIONS TO NON-NETWORK BENEFITS

The benefits provided and percentage paid under the Plan will depend on whether services are received from a Network Provider or a Non-Network Provider. A list of the Network Providers can be obtained from the Plan Administrator.

In order for charges to be eligible for Network Benefits, all services must be provided by a Network Provider, however, Network Benefits will be payable if a Non-Network Physician or facility must be utilized:

1. by a Covered Person due to a medical Emergency; or
2. by eligible students living outside of the Network area.

Network Benefits will also be payable for a Non-Network Physician's services if the Non-Network Physician is based in a Network Hospital (such as an anesthesiologist, pathologists, radiologist or emergency room physicians) and such services are rendered at the Network Hospital.

COST CONTAINMENT FEATURES

The Medical Benefits under this Plan have been designed to encourage a Covered Person to seek quality health care at a lower cost. Medical Benefits will be reimbursed at the levels shown in the Schedule of Benefits if the Covered Person receives an authorization prior to having surgery outside of a Physician's office or if the Covered Person has a Hospitalization pre-certified. If the Covered Person is Hospital confined on an In-Patient basis prior to having that hospitalization pre-certified or the Covered Person fails to have a Second Surgical Opinion when deemed necessary, benefits will be reimbursed at a lower level. The cost containment features under the Plan are as follows:

PRE-CERTIFICATION

PRE-CERTIFICATION IS REQUIRED UNDER YOUR PLAN OF BENEFITS FOR IN-PATIENT HOSPITAL ADMISSIONS AND ANY IN-PATIENT OR OUTPATIENT SURGERY (EXCEPT THOSE PERFORMED IN A PHYSICIAN'S OFFICE).

Pre-certification requires that you or someone from your Physician's office must call the phone number shown below for In-Patient Hospital admissions (as described below) and speak with a nurse in Aultra Administrative Group's (AAG's) Utilization Review Management Department and provide: the patient's name, address, date of birth and relationship to the employee; the employee's identification number, name of the Employer and the group number (information found on your I.D. card); the physician's name, address, telephone number and the name of the facility where the service will be performed; and the dates of the hospitalization and a brief description of the medical treatment plan (what is going to be done and why). If you ask your Physician's office to make the pre-certification phone call and the call isn't made timely (as shown below), then you will be penalized for failure to pre-certify.

NON-EMERGENCY OR ELECTIVE IN-PATIENT HOSPITALIZATIONS: You or your Physician must call the number shown below as soon as possible prior to the proposed Hospital admission.

EMERGENCY HOSPITALIZATIONS AND/OR EMERGENCY IN-PATIENT SURGERIES: You or your Physician must call the number shown below within 48 hours or within two working days following a weekend admission.

PREGNANCY: Pre-Certification does not apply to any normal vaginal delivery for which you are hospitalized for 48 hours or less or to any caesarean section for which you are hospitalized for 96 hours or less. However, if you require additional time in the hospital you or your Physician must call the number shown below within 48 hours or within two working days after the 48 hours for a normal vaginal delivery or the 96 hours for a caesarean section.

OUTPATIENT SURGICAL PROCEDURES: You or your Physician must call the number shown below as soon as possible prior to the proposed surgery.

ADDITIONAL PROCEDURES REQUIRING PRE-CERTIFICATION:

MRI

Injectable Drugs over \$500

Chemotherapy (regardless of where it is performed)

Durable Medical Equipment over \$500

Home Health Care

Hospice

Skilled Nursing Facility

Septo-rhinoplasty, tenotomy or reconstructive surgery

Aultra Administrative Group (AAG)

Nationwide: 1-800-325-8424

IT IS YOUR RESPONSIBILITY TO ENSURE THAT PRE-CERTIFICATION HAS BEEN OBTAINED. IF IT IS NOT OBTAINED WHEN REQUIRED, THE FOLLOWING REDUCTION WILL APPLY:

ELIGIBLE CHARGES IN CONNECTION WITH THESE PROCEDURES, INPATIENT/OUTPATIENT SURGERY AND/OR INPATIENT HOSPITALIZATION WILL BE REDUCED BY A \$250 MAXIMUM REDUCTION AND WILL NOT COUNT TOWARD SATISFACTION OF YOUR CALENDAR YEAR DEDUCTIBLE OR OUT-OF-POCKET MAXIMUM EXPENSE.

PRE-CERTIFICATION OF NON-URGENT CARE CLAIMS (A PRE-SERVICE CLAIM): If the proposed hospitalization requires pre-certification under the Plan, then once the pre-certification phone call is made to Aultra Administrative Group, a benefit determination (whether it's allowable or denied, in whole or in part) will be made and will be provided to you within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the information is received. The written notice will be sent to you in one of the three manners: via mail, via fax or via email.

If a benefit determination cannot be made within the 15 days due to matters beyond the control of the Plan Administrator, then you will be notified prior to the expiration of the initial 15-day period, and there will be an additional 15-day period to make the benefit determination. If an extension of time is needed, you will be provided with an extension notice with an explanation.

If you or your Physician failed to provide needed information when pre-certifying, a notice will be provided within 5 days of the date the pre-certification call is received by Aultra Administrative Group; the notice may be oral, unless you or your authorized representative request written notification. You or your Physician will then have 45 days to provide the missing information. If the missing information is provided to the utilization review department at Aultra Administrative Group within the 45-day period and all information needed to make the benefit determination has been received, then a written notice of the determination will be provided to you. The written notice will be sent in one of three manners: via mail, via fax or via email.

If there is an Adverse Benefit Determination of the Pre-Service non-urgent care claim (if the services or treatment being pre-certified will be denied [in whole or in part]), you will have 180 days in which to appeal the determination. The Plan Administrator will have 30 days (from the date the appeal is received) to make a determination on the appeal. Refer to the section entitled "Claims Information", to the paragraph entitled "Time Limit for Filing Claim Appeals" for additional information on the appeal process.

PRE-CERTIFICATION OF URGENT CARE CLAIMS (A PRE-SERVICE CLAIM): If the proposed hospitalization requires pre-certification under the Plan and the pre-certification claim is a claim for medical care or treatment in which failure to receive prompt care could jeopardize the Covered Person's life or health, or the lack of prompt action could result in severe pain or interfere with his/her ability to regain maximum function, then it will be considered an urgent care pre-certification claim. To determine if a pre-certification claim involves urgent care, the Plan Administrator will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if the Covered Person's Physician determines that the pre-certification claim is an urgent Pre-Service Claim, the claim must be treated as an urgent care claim.

Once the pre-certification is received and has been identified (by the Plan Administrator and/or by the treating Physician) as an urgent care Pre-Service Claim, then a benefit determination (whether it's allowable or denied, in whole or in part) will be made and will be provided to you within a reasonable period of time appropriate to the medical circumstances, but not later than 72 hours after receipt of the information. The benefit determination will be provided orally; a written notice will be furnished not later than 3 days after the oral determination. The written notice will be sent in one of the three manners: via mail, via fax or via email.

If you or your Physician failed to provide needed information when pre-certifying, a notice will be provided within 24 hours of the date the pre-certification call is received by the utilization review department at Aultra Administrative Group (the notice may be oral, unless you or your authorized representative request written notification); you or your Physician will then have a minimum of 48 hours to provide the missing information. Once the missing information is provided to the utilization review department at Aultra Administrative Group, a benefit determination will be provided orally; a written notice will be furnished not later than 3 days after the oral determination. The written notice will be sent in one of three manners: via mail, via fax or via email.

If there is an Adverse Benefit Determination of the Pre-Service urgent care claim (if the services or treatment being pre-certified will be denied [in whole or in part]), you will have 180 days from the receipt of the determination in which to appeal the determination. The Plan Administrator will have 72 hours (from the date the appeal is received) to make a determination on the appeal. Refer to the section entitled "Claims Information", to the paragraph entitled "Time Limit for Filing Claims Appeals" for additional information on the appeal process.

UTILIZATION REVIEW: When a Covered Person is scheduled for admission to a Hospital on an In-Patient basis, notification must be given to Aultra Administrative Group as shown above.

Failure to pre-certify the admission may result in reduced payment in accordance with the provisions shown under the heading "Pre-Certification". During each Hospital stay, an assessment of the individual's ongoing treatment will be confirmed by Aultra Administrative Group. Aultra Administrative Group will also coordinate, as needed, for a prompt discharge from the admitting facility consistent with sound, efficient, medical practice, in consultation with the attending Physician, the admitting facility, and the local community resources.

CONCURRENT REVIEW: Aultra Administrative Group will contact the treating Physician near the end of the Hospital confinement period to verify the Covered Person will be discharged from the Hospital within the time period initially authorized by Aultra Administrative Group. If the admitting Physician determines that the Covered Person needs to be Hospital confined for a longer period than the amount of time which was initially authorized by Aultra Administrative Group, then the additional period of confinement must be certified by Aultra Administrative Group.

If the admitting Physician determines that the concurrent review involves an "urgent care claim", as defined above, and the extension of the hospitalization or further treatment must be decided as soon as possible, then oral notification of the benefit determination will be provided to the claimant within 24-hours after receipt of the concurrent care information requesting an extension, but only if the Physician contacts the utilization review department at Aultra Administrative Group within 24-hours of the expiration of the time period that was initially authorized. If the Physician's request for concurrent review of an "urgent care claim" is not made within at least 24-hours of the expiration of the prescribed period for time or number of treatments, then a benefit determination will be made as soon as possible, but not later than 72-hours after receipt of the request. The notification will be provided orally; a written notice will be furnished not later than 3 days after the oral determination. The written notice will be sent in one of three manners: via mail, via fax or via email. Refer to the section entitled "Claims Information", to the paragraph entitled "Time Limit for Filing Claims Appeals" for additional information on the appeal process.

SECOND SURGICAL OPINION: When a Covered Person has been advised to have surgery, eligible charges in connection with the second (or third) opinion will be paid according to the Schedule of Benefits. If a second opinion does not confirm the need for surgery, a third consultation for a third opinion is subject to any remaining balance of the benefit after the fees of the second physician have been considered. This will be subject to any Major Medical Expense Benefits available. Surgical Opinions must be obtained from a Board Certified Surgeon and must not be affiliated in any way with the physician who will be performing the actual surgery.

OUTPATIENT SURGERY: Frequently, it is possible for Surgery to be performed as a Hospital outpatient, in a Physician's office or in a freestanding surgical center. Outpatient Surgery is normally more convenient and less costly since the expense of inpatient Hospital care is avoided. This Plan encourages Outpatient Surgery. For the following surgical procedures, Outpatient Surgery is REQUIRED, unless inpatient Surgery is Medically Necessary and advance approval is obtained from AAG's utilization department.

The following procedures are required by the Plan to be Outpatient:

- Laparoscopic Surgery
- Colonoscopy
- Cystoscopy
- Upper Intestinal Endoscopy
- Cataract Surgery
- Morton's Neuroma
- Excision/Destruction of Lesion
- Circumcision
- Breast Biopsy
- Tonsillectomy
- Dilation & Curettage
- Carpal Tunnel
- Arthroscopy/Arthroscopic Surgery
- Vasectomy

LARGE CASE MANAGEMENT: When a Covered Person's condition (such as a catastrophic Injury or chronic Illness) warrants, the person's attending Physician will be contacted to review all available resources that may be utilized to maximize the person's recovery. Areas that may be reviewed with the attending Physician include rehabilitation resources, public assistance programs, and alternative forms of treatment. Under certain unusual or specialized circumstances, the Plan Administrator may consider covering charges that would not be covered by the Plan, but only if the proposed treatment proves to be approved by the medical community and would be more cost effective than an alternative form of treatment which would otherwise be eligible for benefits under the Plan. Prior to any final determination, however, the length, severity, and prognosis of the person's condition will be taken into consideration, however, the decision on the course of treatment selected ultimately lies with the Covered Person. Large Case Management provides suggested, not mandatory, treatment care plans.

PRE-EXISTING CONDITIONS

A "*Pre-Existing Condition*" is any condition, other than pregnancy, that exists during the six (6) months immediately prior to the earlier of the Covered Person's effective date of medical coverage under this Plan or, if earlier, the first day of any Waiting Period before which the Covered Person is eligible to enroll under this Plan, for which the Covered Person either:

1. received medical treatment, consultation, care or services including diagnostic measures from a state-licensed medical practitioner; or
2. took prescribed drugs or medicines.

Pre-existing conditions, as defined above, are not covered under the Plan. However, this limitation shall not apply to any expenses incurred after the end of a period of time equal to twelve (12) consecutive months less the Covered Person's period of Creditable Coverage (if any), or in the case of a late enrollee, the end of a period of time equal to eighteen (18) consecutive months less the Covered Person's period of Creditable Coverage (if any).

The Plan's Pre-existing Condition limitation will be reduced in the following manner for Creditable Coverage:

1. The eligible person's enrollment date will be determined. This is the earlier of the person's effective date of medical coverage under this Plan or, if earlier, the first day of any Waiting Period before which the person is eligible to enroll under this Plan.
2. Counting backwards from the enrollment date, the number of consecutive days of Creditable Coverage the person had will be identified.
3. Once there is any break in the consecutive days of Creditable Coverage, not counting breaks due to Waiting Periods or HMO Affiliation Periods, the number of days in this break will be counted:
 - a) if the number of days in the break is sixty-three (63) or more, only the days of Creditable Coverage until this break are credited towards this Plan's Pre-Existing Condition limitation.
 - b) if the number of days in the break is less than sixty-three (63), the break is ignored and counting is resumed.
4. Counting continues until the person has twelve (12) months of Creditable Coverage, eighteen (18) months in the case of a late enrollee, or until there is a sixty-three (63) day break in coverage.

The Pre-Existing Condition limitation under this Plan will be waived for an eligible Employee's newborn child or adopted child, under the age of 18, if the Employee enrolls that child within 30 days of birth, adoption, or placement for adoption.

A Covered Person may demonstrate Creditable Coverage by requesting and obtaining a certificate of Creditable Coverage from a prior health plan and presenting this certificate to the Third Party Administrator. "*Creditable Coverage*" shall have that definition contained in ERISA Section 701(c). Under this provision, Creditable Coverage generally includes periods of coverage under an individual or group health plan (including Medicare, Medicaid, governmental and church plans) that are not followed by a significant break in coverage of sixty-three (63) days or more. Creditable Coverage does not include coverage for liability, dental, vision, specified disease and/or other supplemental-type benefits.

If the Plan imposes a pre-existing condition exclusion after receiving information concerning an individual's prior coverage, the individual will be provided a written notice including the period for which the exclusion applies, the basis used to determine that the exclusion applies, and the Plan's appeals procedures.

In no event, will the above modifications or waivers be construed to imply that this Plan will cover any expenses other than those which are eligible for benefits under this Plan. In addition, the total amount payable under this Plan will not exceed any maximums shown in the Schedule of Benefits.

MEDICAL BENEFITS

DEDUCTIBLES, COINSURANCE, AND COPAY

BASIC BENEFITS: "Basic Benefits" means those Eligible Expenses, which are not subject to any Deductible, Coinsurance or Copay provision. (If included as a Plan Benefit, Supplemental Accident benefits will be paid before any other "Basic Benefits" are paid.)

MAJOR MEDICAL BENEFITS: Major Medical Benefits supplement Basic Benefits, if any, to provide the best protection against the large medical bills that can result from Illness or Injury. This is the way it works:

If expenses exceed the maximum provided by the basic benefits, or if expenses are not covered by the Basic Benefits, then, after paying the Calendar Year Deductible (if applicable), Major Medical takes over and pays the major part of the balance of Eligible Expenses. Charges excluded under the Plan are not considered Eligible Expenses.

DEDUCTIBLE: The Network Calendar Year Deductible, as shown in the Schedule of Benefits, is the amount of Eligible Expenses which must be incurred by each Covered Person (if applicable) before any Major Medical benefits are payable for eligible Network expenses, unless stated otherwise in the Schedule of Benefits. The Non-Network Calendar Year Deductible, as shown in the Schedule of Benefits, is the amount of Eligible Expenses which must be incurred by each Covered Person (if applicable) before any Major Medical benefits are payable for eligible Non-Network expenses, unless stated otherwise in the Schedule of Benefits.

If a combination of Network and Non-Network providers are utilized, charges applied to the Network Deductible will not be applied towards the Non-Network Deductible; charges applied to the Non-Network Deductible will not be applied towards the satisfaction of the Network Deductible.

If more than one Covered Person in a family incurs expenses during a Calendar Year and the accumulated expenses payable by those individuals exceed the Network Family Deductible shown in the Schedule of Benefits, the Network Deductible will be considered to be satisfied for all other Family members for the remainder of that Calendar Year.

If more than one Covered Person in a family incurs expenses during a Calendar Year and the accumulated expenses payable by those individuals exceed the Non-Network Family Deductible shown in the Schedule of Benefits, the Non-Network Deductible will be considered to be satisfied for all other Family members for the remainder of that Calendar Year.

Any amounts paid by an individual for the following will not apply towards the satisfaction of the Calendar Year Deductible shown in the Schedule of Benefits:

1. Any charge which is not eligible under the Plan; or
2. Reductions in Covered charges which must be paid by a Covered Person due to failure to pre-certify a Hospital admission or In-patient surgery; or
3. All Copays.

The Plan Administrator reserves the right to allocate the Calendar Year Deductible amount to any eligible charges and to apportion the benefits to the Covered Person and any assignee. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

COMMON ACCIDENT PROVISION: If two or more Covered Persons of a Family incur expenses as a result of the same accident, then a total of one Individual Calendar Year Deductible is all that is required for covered services that result directly from this accident during the Calendar Year.

DEDUCTIBLE CARRY OVER PROVISION: If a Covered Person has expenses which are applied to the Calendar Year Deductible and were incurred during the last three (3) months of a Calendar Year, these covered expenses will be applied toward the individual's Calendar Year Deductible amount for the subsequent Calendar Year. Deductibles satisfied because of a common accident provision shall not be considered Eligible Expenses as to the Carryover provision of this Plan.

COPAY: When a Network Physician is utilized for office calls, the "Copay" is the amount shown in the Schedule of Benefits, which each covered individual must pay for each office visit charge. Amounts paid as "Copays" do not count towards the satisfaction of the Calendar Year Deductible or your share of the Coinsurance as shown in the Schedule of Benefits.

COINSURANCE: Unless otherwise shown under the Schedule of Benefits, the Plan will pay 85% or 70% of Eligible Expenses until the applicable Out-of-Pocket Maximum has been met. Once the Network Out-of-Pocket Maximum has been met, the Plan will pay 100% of all remaining Network Eligible Expenses for the remainder of the Calendar Year. Once the Non-Network Out-of-Pocket Maximum has been met, the Plan will pay 100% of all remaining Eligible Expenses for the remainder of the Calendar Year. When BOTH Network and Non-Network providers are utilized by a Covered Person during any Calendar Year. Network Out-of-Pocket Expenses will not apply toward the satisfaction of the Non-Network Out-of-Pocket Maximum; Non-Network Out-of-Pocket Expenses will not apply toward the satisfaction of the Network Out-of-Pocket Maximum.

If more than one Covered Person in a Family incurs accumulated Eligible Expenses during a Calendar Year that exceed the Family Network Out-of-Pocket Maximum shown in the Schedule of Benefits, the Network Out-of-Pocket Maximum will be considered to be satisfied for all other Family members for the remainder of that Calendar Year; if they exceed the Family Non-Network Out-of-Pocket Maximum shown in the Schedule of Benefits, the Family Non-Network Maximum will be considered satisfied for all other Family members for the remainder of that Calendar Year.

Any amounts paid by an individual for the following *will not* apply towards the satisfaction of your share of the Coinsurance (it will not apply to your Out-of-Pocket Maximum) shown in the Schedule of Benefits and will never be paid at 100%:

1. Expenses which are not eligible under the Plan; or
2. Outpatient treatment of Non-Biologically based Mental and/or Nervous Disorders; or
3. Outpatient treatment of Alcohol and/or Drug Abuse; or
4. Reductions in Covered charges which must be paid by a Covered Person due to failure to pre-certify a Hospital admission or In-patient surgery; or
5. All Copays.

LIFETIME MAXIMUM: The maximum payable for all Eligible Expenses for each Covered Person shall not exceed, in the aggregate, the Lifetime Maximum amounts shown in the Schedule of Benefits.

ELIGIBLE MEDICAL EXPENSES

A COVERED MEDICAL EXPENSE IS CONSIDERED INCURRED ON THE DATE THE MEDICAL CARE, SERVICES, OR SUPPLIES ARE PROVIDED.

COVERED MEDICAL EXPENSES SHALL INCLUDE, SUBJECT TO THE GENERAL LIMITATIONS, ONLY REASONABLE AND CUSTOMARY CHARGES FOR SERVICES AND SUPPLIES WHICH ARE INCURRED BY A COVERED PERSON AND ARE:

1. Administered or ordered by a Physician; and
2. Medically Necessary for the diagnosis and treatment of an Illness or Injury unless otherwise specifically excluded as a Covered Expense; and
3. Not excluded under any provision or section of this Plan.

ELIGIBLE MEDICAL EXPENSES ARE LIMITED TO:

1. Expenses incurred at a Hospital for room and board, but not to exceed the average "Semi-Private" room rate, intensive care or cardiac care room rate, and other Hospital services required for purposes of treatment.
2. Charges made by a Child Birthing Center including room and board, miscellaneous, lab work, professional fees, delivery, facility use, supplies, prenatal and postpartum care and exams.
3. Charges made by an Ambulatory Surgical Center, Minor Emergency Medical Clinic or Urgent Care Facility.
4. Emergency Services will be covered according to the Schedule of Medical Benefits.
5. Charges made for Home Health Care up to the maximum shown in the Schedule of Benefits for services that are Medically Necessary for the care and treatment of a covered Illness or Injury furnished to a Covered Person at his or her place of residence.
6. Charges made for Inpatient or Outpatient Hospice Care including semi-private room and board if provided on an Inpatient basis; pre-death counseling and bereavement counseling for the terminally ill individual and his covered Family during the individual's Illness; and medical social services. (Please see the section entitled "Description of Medical Benefits" for further details.)
7. Charges made by a Skilled Nursing Facility during a Convalescent Period up to the maximums shown in the Schedule of Benefits including charges for room and board and general nursing services based on the daily room benefit of the Skilled Nursing Facility's Semi-Private room rate. (Please see the section entitled "Description of Medical Benefits" for further details.)
8. Expenses for the services of a legally qualified Physician for medical care and/or surgical treatment.
9. Fees of a registered graduate nurse (R.N.) for private duty nursing services only when ordered by a Physician. Nursing services do not include care which is primarily non-medical or custodial in nature.
10. Charges for professional Ambulance service to the nearest facility where Emergency care or treatment is rendered or to the nearest facility where the Covered Person may be transferred for care when it is documented that the first facility does not have the required services and/or facilities to treat the Covered Person. Air Ambulance is covered only when terrain, distance or the Covered Person's condition warrants. Ambulance charges for convenience are not covered.
11. Charges for drugs requiring the written prescription of a licensed Physician which are not eligible expenses under the Prescription Drug Benefit and which must be filled by a licensed pharmacist are covered at the Network level of benefits.
12. Charges for diagnostic x-ray and laboratory tests, electrocardiograms (EKG), electroencephalogram (EEG), pneumoencephalograms, basal metabolism tests, MRI's, CT scans or similar well established diagnostic tests generally approved by Physicians throughout the United States.

13. Charges for radiation therapy and chemotherapy.
14. Charges for physical therapy and/or rehabilitation services if related to a covered Illness or Injury.
15. Fees of a legally qualified Physician or qualified speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to a covered Illness or Injury other than a functional nervous disorder, or due to Surgery performed on account of a covered Illness or Injury. If the speech loss is due to congenital anomaly, surgery to correct the anomaly must be performed prior to the therapy.
16. Expenses for occupational therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Illness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.
17. Expenses for respiratory therapy by a licensed therapist for which measurable improvement is expected within a reasonable period of time.
18. Expenses for allergy testing, extract and injections when rendered by a Physician or other provider, but only up to the maximum shown in the Schedule of Medical benefits.
19. Charges for the cost, processing and administration of blood or blood components.
20. Charges for anesthetics, oxygen and other gases, and their administration.
21. Charges for medical supplies including but not limited to: dressings, sutures, casts, splints, trusses, crutches, colostomy bags, catheters, syringes and needles for administering covered drugs, medicines or insulin (including glucometers) when not an eligible expense under the Prescription Drug Benefit.
22. Charges for the rental or purchase (whichever is less) of Durable Medical Equipment prescribed by a Physician; wheelchair, hospital bed or other Durable Medical Equipment required for temporary therapeutic use.
23. Expenses for a wig or artificial hairpiece but only if necessitated by medically necessary treatment.
24. Charges for prosthesis and orthopedic appliances; artificial limbs, eyes, pacemakers, larynx, cervical collars, braces; breast prosthesis to include special bras (limited to 2 bras per Calendar Year). The initial purchase, fitting, repair and replacement of orthotic appliances such as braces, splints, or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition, an injury or illness. Replacements will only be covered if Medically Necessary and not as the result of loss, theft, or damage. Dental braces and corrective shoes are not covered.
25. Charges made for voluntary sterilization, but not their reversal.
26. Expenses in connection with fertility studies or sterility studies necessary to diagnose the condition.
27. Charges for services and supplies in connection with non-Experimental organ transplant procedures. (Please see section entitled "Description of Medical Benefits" for further details.)
28. Charges for dental services provided by a dentist, oral surgeon or Physician, including all related charges for: 1) repair to sound natural teeth due to accidental Injury in order to restore them to their condition prior to the accident; 2) extraction of full & partial bony impacted teeth. All oral surgeons are to be paid at the Network level of benefits. Charges for Hospital expenses in connection with dental services, but only if it is deemed Medically Necessary for the Covered Person to be treated in or confined in a Hospital, due to a medical condition which could jeopardize the individual's life if the services were not rendered in a Hospital.
29. Charges for services, including related x-rays, to detect and/or correct (by manual or mechanical manipulation) structural imbalance, distortion or subluxation in the human body for the removal of nerve interference, when the nerve interference is the result of or related to such problems in the vertebral column, musculoskeletal, or allied modalities. Charges made by a chiropractor for benefits that exceed the maximum specified in the Schedule of Benefits and/or is determined to be for maintenance, palliation, or excessive care may not be considered a covered expense.

30. Charges for treatment of kidney disorders by hemodialysis or peritoneal dialysis.
31. Expenses for Physician office calls, x-rays, lab work and related tests, immunizations, routine cancer screenings, routine mammograms, routine prostate exam and routine gynecological exam/pap smear, in connection with routine physicals but only up to the maximums shown in the Schedule of Benefits.
32. Expenses for Physician office charges, x-rays, lab work and related tests, and immunizations, in connection with routine "well child care" physicals but only up to the maximums shown in the Schedule of Benefits.
33. Charges related to the Pregnancy of all Covered Persons.
34. Expenses related to Attention Deficit Disorder (ADD).
35. Expenses for care, supplies and treatment of Mental/Nervous Disorders and Alcohol and/or Substance Abuse, up to the maximums shown in the Schedule of Medical Benefits. Expenses for the diagnosis and treatment of biologically based mental illnesses are covered on the same terms and conditions as those provided for the treatment of physical disorders. Non-Biologically Based Mental Illness shall be covered up to the maximums shown in the Schedule of Benefits.
36. Charges for Injuries as a result of an act of domestic violence.
37. Charges for bio-feedback.
38. Charges made by a licensed massotherapist, up to the maximum shown in the Schedule of Benefits.

DESCRIPTION OF MEDICAL BENEFITS

THE FOLLOWING PARAGRAPHS, FURTHER DESCRIBE THE MEDICAL BENEFITS PROVIDED UNDER THE PLAN.

CARDIAC REHABILITATION: Phase I and II will be covered benefits; Phase III is not covered.

Phase I begins approximately 2-4 days following a heart attack, or 24 hours post heart Surgery. Patients are assisted through range of motion exercises, which gradually progress to walking or stair climbing by the time of discharge.

Phase II is an outpatient, Hospital based program, usually of 2-3 months duration. Patients engage in a monitored program of exercise therapy, health education and individualized or group support sessions.

Phase III is an outpatient exercise program held at various community fitness facilities. Patients engage in conditioning activities supervised by a Registered Nurse and an exercise physiologist. **Phase III is not a Covered Expense.**

HOME HEALTH CARE: The Plan pays for charges made by a Home Health Care Agency for care in accordance with a Home Health Care Plan, up to the amount shown in the Schedule of Benefits . Eligible expenses include:

1. Part-time or intermittent nursing care by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.), a licensed vocational nurse (L.V.N.) or a public health nurse who is under the direct supervision of a registered nurse;
2. Home Health Aides
3. Medical supplies, drugs and medicines prescribed by a physician, and laboratory services provided by or on behalf of a hospital but only to the extent that they would have been covered under this Plan if the Covered Person had remained in the Hospital.

Specifically excluded from coverage under this benefit are:

1. Services and supplies not included in the Home Health Care Plan;
2. Services of a person who ordinarily resides in the home of the Covered Person, or is a relative of the Covered Person;
3. Services of any social worker;
4. Transportation services.

HOSPICE CARE: The Plan pays for the following Hospice Care charges on a Reasonable and Customary basis when a Covered Person's Physician certifies that he has a Terminal Illness with a life expectancy of six (6) months or less which requires Hospice Care:

1. Charges made by an Inpatient hospice facility for Palliative Care but not to exceed the Reasonable and Customary Semi-Private Room Rate charged by a Hospital;
2. Charges made for Outpatient Hospice Care through a centrally administered, medically directed and Nurse coordinated program which a) provides an organized system of home care; and b) uses a Hospice Team, and; c) is available 24-hours-a-day, 7-days-a-week;
3. Pre-death counseling and bereavement counseling for the terminally ill Covered Person and his covered Family during the Covered Person's Illness, and until six (6) months after the Covered Person's death;
4. Medical social services. These services include:
 - a) assessment of the social and emotional factors related to the Covered Person's terminal Illness, need for care, response to treatment, and adjustment to care; and
 - b) action to obtain casework services to assist in resolving problems in these areas; or
5. Pastoral counseling, other than counseling provided by a licensed pastoral counselor to a member of his congregation in the course of duties to which he has been called as a pastor or minister.

Charges not covered under Hospice Care are charges for:

1. Pre-death counseling and bereavement counseling which is not provided by or through the hospice program of care; or
2. Services provided by homemakers, caretakers and the like; or
3. Funeral services and arrangements; or
4. Curative treatment or services; or
5. Services and supplies that are not for the palliation or management of terminal Illness.

HOSPITAL BENEFITS: When hospitalized in a licensed Hospital, benefits will be paid on a Reasonable and Customary basis. Covered expenses include, but are not limited to, those for: room and board, Intensive Care Unit, cardiac care unit, operating, recovery, neo-natal unit, and delivery rooms, and other Medically Necessary services and supplies. Room and board will be paid up to the Hospital's standard Semi-Private room rate. Charges for a private room will be an eligible expense if the Hospital has no Semi-Private rooms, the Covered Person has a communicable disease or the private room is Medically Necessary for treatment of the Covered Person's condition. The Plan pays for fees charged by a Physician for visits made while confined in the Hospital.

Successive periods of Hospital confinement shall be considered one period of confinement, unless as an Employee you return to work on a Full-Time basis, or as a Dependent, a subsequent confinement is separated by a period of at least three (3) months.

Benefits are also payable for Outpatient Hospital services and charges made by the Hospital. Outpatient services pays for Emergency treatment of an Illness and/or Injury, and Hospital facilities used relating to minor surgery or an acute Emergency Illness.

MENTAL OR NERVOUS DISORDERS AND ALCOHOL AND/OR DRUG ABUSE:

In-Patient: Payment for covered medical expenses incurred for *Non-Biologically Based* Mental and/or Nervous Disorders and/or Alcohol and/or Drug Abuse during confinement in a Hospital or Alcohol, Drug Abuse or Psychiatric Treatment Facility will be paid on a Reasonable and Customary basis up to the maximums shown in the Schedule of Benefits for these expenses.

Out-Patient: Payment for covered medical expenses incurred for *Non-Biologically Based* Mental and/or Nervous Disorders and/or Alcohol and/or Drug Abuse, when provided on an Outpatient Basis at a Physician's office; Hospital; Alcohol, Drug Abuse or Psychiatric Treatment Facility; or other Outpatient facility, will be paid up to the maximums shown in the Schedule of Benefits.

If a Covered Person is partially confined, two days of partial confinement will be considered as one day of confinement. "*Partial confinement*" means treatment for at least 3 hours but no more than 12 hours in any 24-hour period.

The Calendar Year Maximum and Lifetime Maximum benefits (if applicable) are shown in the Schedule of Benefits.

Biologically Based Mental Illness will be treated as any other illness under this Plan, subject to applicable deductible and coinsurance. (Please see the section entitled "Definitions" for a description of Biologically Based Mental Illness.)

ORGAN TRANSPLANTS: The Plan will pay for services and supplies in connection with non-experimental cornea, bone marrow, kidney, heart, heart-lung, liver and pancreas organ transplant procedures, subject to the following conditions:

1. If the recipient is covered under this Plan, eligible medical expenses incurred by the recipient will be considered for benefits. Expenses which are related to the donation and are incurred by the donor, who is not ordinarily covered under this Plan according to the Plan's eligibility requirements, will be considered Eligible Expenses to the extent that such expenses are not payable by the donor's coverage. In no event will benefits be payable in excess of the Lifetime Maximum Benefit still available to the recipient.
2. If both the donor and the recipient are covered under this Plan, eligible medical expenses incurred by each Covered Person will be treated separately for each Covered Person.
3. If the recipient is not covered under this Plan, the donor's expenses are not covered.
4. 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 charge.

However, in reference to item number 2 and 3 above, if the Plan's expenses for the transplant are covered by a separate transplant contract with the Hospital in which the transplant occurs, and such contract contains a global case fee which includes the cost of the donor's eligible expenses, then all eligible benefits will be payable for the donor under this Plan (will not be coordinated with the donor's plan).

PRE-ADMISSION TESTING: Charges for pre-admission testing are covered under the Plan for x-rays and other tests as shown in the Schedule of Benefits when such testing is performed on an Outpatient basis prior to an In-Patient confinement. Charges will not be considered eligible for the Pre-admission Testing benefit if the Covered Person refuses to undergo, cancels or postpones the surgery or hospitalization, except when due to reasons beyond the Covered Person's control.

The pre-admission testing benefit will only be paid for x-rays and other tests performed after the date the Physician schedules the surgery.

PREGNANCY BENEFITS: Benefits for Pregnancy are treated as any other Illness under the Plan. An initial Routine Maternity ultrasound is covered, however subsequent ultrasounds are not covered unless medically necessary.

Routine nursery care for a newborn child is covered as any other Illness, provided the child is enrolled for coverage under this Plan within the time periods specified under the section entitled "Dependent Enrollment". This benefit is to cover Hospital or Child Birthing Center charges incurred at the time of birth and circumcision. Routine charges for a well baby after the earlier of a) the mother's release from the Hospital or Child Birthing Center; or b) 5 days are not covered.

Newborns' and Mothers' Health Protection Act

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 for the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider (for example, your physician), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay of up to 48 hours (or, of up to 96 hours for a cesarean section). For further information, please refer to the "Pre-certification" section of your booklet for the paragraph entitled "Pregnancy" or contact your Plan Administrator.

ROUTINE PHYSICALS: Routine office exams including related tests and x-rays, immunizations, routine gynecological exam/pap smear, routine mammogram, routine prostate exam, routine eye exam and routine hearing exam are covered on a Reasonable & Customary basis under the Plan but only up to the maximums shown in the Schedule of Benefits.

Charges will only be paid as a routine or preventive expense when there is no diagnosis of Illness or Injury connected to the service provided.

SKILLED NURSING FACILITY: Payment is to be made for daily charges for room and board and general nursing services in a licensed, Skilled Nursing Facility based on the daily room benefit of the Skilled Nursing Facility's Semi-Private room rate up to the maximums shown in the Schedule of Benefits subject to the following conditions:

1. the Covered Person has first had a Hospital stay of at least 3 consecutive days;
2. the Covered Person's stay in the Skilled Nursing Facility starts within 14 days after the end of the Hospital stay.

If the Covered Person leaves a Skilled Nursing Facility and is readmitted within 14 days, that person does not have to have a new 3-day stay in the Hospital to be covered.

A Convalescent Period will end when the Covered Person has been free of confinement, in any and all institutions providing Hospital or nursing care, for a period of fourteen (14) consecutive days. A new convalescent period shall not begin until a previous convalescent period has ended.

"*Convalescent Period*" is a period of time beginning with the date of confinement by a Covered Person to a Skilled Nursing Facility. A "*Confinement Period*" begins within fourteen (14) days after a three (3) day Hospital stay. Both the Hospital and convalescent confinement must have been for the care and treatment of the same Illness or Injury.

SURGICAL BENEFITS: Surgical Benefits are provided for operations resulting from an Illness or Injury. Surgical benefits will be paid on a Reasonable and Customary basis and are payable whether the operation is performed in a Hospital, Ambulatory Surgical Center or in a Physician's office.

If the Physician charges for two or more surgical procedures performed during a single operative session, the Reasonable and Customary charge for each procedure will be determined based on: 1) if surgery is performed through a single or through a separate incision; 2) operative site; and 3) single versus bilateral procedures. Fractures will not be considered, for the purposes of this document, bilateral procedures. The application of "Reasonable and Customary" to the multiple surgery charges may reduce the amount of the charges considered eligible for the additional procedures.

WELL CHILD CARE: "Well-Child Care" means medical treatment, services or supplies rendered to a child or newborn solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.

Routine office exams including related tests, x-rays and immunizations are covered on a Reasonable & Customary basis under the Plan but only up to the maximums shown in the Schedule of Benefits.

Charges will only be paid as a routine or preventive expense when there is no diagnosis of Illness or Injury connected to the service provided.

MEDICAL EXCLUSIONS AND LIMITATIONS

THE FOLLOWING ARE NOT ELIGIBLE FOR MEDICAL BENEFITS UNDER THE PLAN; HOWEVER, CERTAIN CHARGES MAY BE ELIGIBLE UNDER THE PLAN'S DENTAL OR DRUG BENEFITS.

Any expense incurred in connection with services or supplies which are not Medically Necessary for the treatment of an Illness or Injury (unless specifically shown as a covered expense under the Plan) and which are not recommended, approved or provided by a Physician, including, but not limited to:

1. Expenses for routine medical exams, vaccinations, immunizations, preventive shots, or any charge for any examination for check-up purposes not incidental to or necessary to diagnose an Illness or Injury (other than covered benefits outlined in the Schedule of Benefits or elsewhere in this Plan);
2. Expenses or treatment, supplies, instructions or activities for weight reduction, weight control, or physical fitness including expenses for Gastric Bypass or any surgical procedure for weight reduction;
3. Expenses for educational training, instruction or educational materials;
4. Expenses for deluxe or luxury items; air conditioners, purifiers; dehumidifiers, corrective shoes, heating pads, hot water bottles, exercise equipment, whirlpools, waterbeds, and other clothing and equipment which is not medical in nature regardless of the relief they provide for a medical condition;
5. Expenses for any confinement in an institution primarily to change one's environment;
6. Expenses for genetic counseling, including tests to determine the sex of an unborn child;
7. Expenses for mailing, telephone consultations, sales tax, preparing reports, preparing itemized bills, completing claim forms or telephone consultations;
8. Any expense incurred in connection with an Injury or Illness for which the Covered Person is not under the care of a Physician;
9. Any charges incurred for Experimental treatment or drugs;
10. Any expense for a Cosmetic Procedure except when due to a) a congenital anomaly of a covered newborn or for a covered child if the procedure was delayed due to medical necessity; or b) an Injury; or c) the surgical removal of all or part of the breast tissue solely because of an Illness or Injury to the breast to include surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complication at all stages of the mastectomy, including lymph edemas; or d) for reconstructive surgery as necessary for the prompt treatment of a diseased condition;
11. Any services, treatment, or supplies intended to prevent hair loss or induce hair growth; or
12. Any expenses related to Custodial Care, sanitarium care, rest care, or charges made by a Hospital for a confinement primarily for physiotherapy or hydrotherapy;
13. Expenses for hearing aids, batteries or repairs except for the initial purchase of a hearing aid if the loss of hearing is a result of a surgical procedure;
14. Any expenses for eyeglasses, correction of vision for the purpose of refraction, radial keratotomy or radial keratoplasty, fitting of glasses or eye examinations, except for the first pair of glasses or lenses prescribed as a result of a) cataract surgery or b) an accidental Injury or c) the first pair of lenses prescribed as a therapeutic treatment of keratoconus;
15. Expenses or treatment for foot care for flat foot conditions, the treatment of subluxation of the foot, care or removal of corns, care of bunions (except capsular or bone surgery), care or removal of calluses, care or removal of toe nails (except surgery for ingrown nails), treatment for fallen arches, weak feet and chronic foot strain. Charges for the cutting or removal of corns, calluses or toenails will be covered when an underlying medical condition such as diabetes or hardening of the arteries has been diagnosed;

16. Expenses related to the treatment of infertility, procedures to restore or enhance fertility, artificial insemination, in vitro fertilization, pregnancy of a surrogate mother or expenses in connection with fertility studies or sterility studies beyond the period necessary to diagnose the condition;
17. Expenses incurred as a result of sex change procedures, sexual dysfunction and/or inadequacies, or impotence, including medications used for the treatment of impotency, including but not limited to Viagra;
18. Any expenses for charges made by a counselor, psychologist, or psychiatrist for the treatment of functional nervous disorders (such as learning disorders, autism, mental retardation, or senility) beyond the period necessary to diagnose the condition;
19. Any expenses related to counseling for "Transient Situational Adjustments" (such as marital problems, family problems, behavioral problems, or social problems) unless such counseling is necessary for the treatment of a diagnosed Mental and/or Nervous Disorder;
20. Expenses for prescription drugs or substances which are eligible expenses under the Prescription Drug Benefit.
21. Expenses for vitamins or nutrition supplements;
22. "Oriental Pain Control" or acupuncture unless performed by a Physician or under the supervision of a Physician;
23. Dental services or dental supplies of any kind except those specifically shown as an eligible medical expense under this Plan, including charges for Temporomandibular Joint Dysfunction (TMJ);
24. Any expenses for occupational, speech or orthopedic therapy or training unless related to a covered Illness or Injury;
25. Any charge for any condition, Disability or expense resulting from or sustained as a result of war or act of war, declared or undeclared;
26. Any charges for any condition, Disability or expense resulting from or sustained as a result of being engaged in an illegal occupation, commission of or attempted commission of an assault or a felonious act or aggravated assault;
27. Any expense for care or treatment provided or furnished by the United States Government or in any other Hospital operated by a government of any country if in-service related;
28. Any expenses for any condition or Disability which would entitle the Covered Person to any benefit under Worker's Compensation Act or similar legislation or which is due to Injury or Illness arising out of or in the course of any occupation or employment for wage or profit;
29. Any expense for professional services performed by a person who ordinarily resides in the Covered Person's household or who is related to the Covered Person, such as a spouse, parent, child, brother, or sister, whether such relationship is by blood or exists in law;
30. Services or supplies for which there is no legal obligation to pay, or charges which would not be made but for the availability of benefits under this Plan;
31. Expenses incurred in connection with any intentionally self-inflicted Illness or Injury; suicide or attempted suicide, unless the act is the direct result of a mental or physical condition;
32. Any expense which exceeds the Reasonable and Customary expense for the care rendered;
33. Travel expenses of a Physician or travel expenses of a Covered Person, even if recommended by a Physician, unless specifically shown as an "Eligible Medical Expense";
34. Charges incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining medical service, drugs, or supplies;
35. Charges for elective abortions;

36. Expenses for the treatment of nicotine habit or addiction;
37. Charges for contraceptive management, except for vasectomy, tubal ligation, generic birth control pill only, and Depo-Provera.
38. Charges incurred by the Covered Person prior to the effective date of coverage and/or after the date of termination of coverage, except as otherwise indicated.
39. Expenses for anesthesia services when provided for surgical services not covered by the Plan; and the administration of local anesthesia for dental services.
40. Charges incurred for court ordered treatment and/or testing.
41. Charges for any items or services, supplies or treatment not specifically listed in this Plan as covered services.

UPON TERMINATION OF THIS PLAN, ALL CLAIMS INCURRED PRIOR TO TERMINATION OF THIS PLAN, BUT NOT SUBMITTED TO THE THIRD PARTY ADMINISTRATOR, AS DEFINED HEREIN, WITHIN SIXTY (60) DAYS OF THE EFFECTIVE DATE OF THE TERMINATION OF THIS PLAN, WILL BE EXCLUDED FROM ANY BENEFIT CONSIDERATION.

DESCRIPTION OF PRESCRIPTION DRUG BENEFITS

(CAREMARK PRESCRIPTION DRUG PROGRAM)

Caremark Prescription Drug Benefit provides payment for eligible prescription drug charges at 100% after the per prescription, co-payment for prescriptions purchased at a Network Pharmacy or through the Mail Order Program.

Caremark operates a national **retail pharmacy** network linking over 50,000 participating locations.

Caremark's **mail service pharmacy** reduces the cost of maintenance medications for both plan sponsors and their participants, while offering greater convenience to each. Patients send prescriptions or refill orders to the mail service pharmacy, where they are processed, dispensed, and checked before being mailed to the patient's home or office. The process eliminates claim forms and reduces dispensing fees, plan billing expenses, and related paperwork. Participants enjoy the convenience of having their medications delivered to their door and not having to file claims or wait for reimbursement.

If you're a Caremark member and you have a question about your prescription benefit, visit the member services site at www.rxrequest.com or contact customer service at 1-800-841-5550.

To make a general inquiry, contact the corporate offices at:

Caremark Inc.
2211 Sanders Road
Northbrook, Illinois 60062
(800) 323-8083

DESCRIPTION OF DENTAL BENEFITS

Dental Benefits will be paid as shown in the Schedule of Benefits providing the person has dental coverage and the charges incurred are eligible. Eligible charges will be based on the Reasonable and Customary Fees. The Plan may agree to accept as covered dental expenses, expenses for services not listed. To be considered, services should be identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature and/or by description and submitted to the Plan.

The Plan will determine the maximum covered expense for service that it accepts. The maximum covered expense so determined will be consistent with the maximums listed.

For the purpose of this Plan, any Class I or Class II dental service as shown in the Schedule of Dental Benefits, will be considered a Class IV dental service when performed for or in connection with orthodontic treatment.

When a Covered Person submits a claim for benefits under this Plan, the Employee and his attending Physician/Dentist should complete and return the claim form, together with original bills of Dental expenses. A Dental claim form is required for each Dental claim. Billing statements are not acceptable without a completed Claim form.

DENTAL DEDUCTIBLES AND COINSURANCE

DEDUCTIBLE: The Calendar Year Deductible, as shown in the Schedule of Benefits, is the amount of Eligible Basic and/or Major Expenses which must be incurred by each Covered Person (if applicable) before any benefits are payable, unless stated otherwise in the Schedule of Dental Benefits.

If more than one Covered Person in a family incurs expenses during a Calendar Year and the accumulated expenses payable by those individuals exceed the Family Deductible shown in the Schedule of Benefits, the Deductible will be considered to be satisfied for all other Family members for the remainder of that Calendar Year.

The Calendar Year Deductible does not apply to eligible Preventive Care Services or Orthodontia Services. However, Orthodontia has a separate Lifetime Deductible as shown in the Schedule of Dental Benefit for each person.

The Plan Administrator reserves the right to allocate the deductible amount to any eligible charges and to apportion the benefits to the Covered Person and any assignee. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

DENTAL DEDUCTIBLE CARRYOVER: Eligible dental expenses applied during the months of October, November and December will be used to reduce the amount of the deductible for the following Calendar Year.

COINSURANCE: Unless otherwise shown, the Plan will pay the applicable percentage rate as shown in the Schedule of Benefits for Eligible Expenses which exceed the Calendar Year Deductible, if applicable, up to the maximums shown in the Schedule of Benefits.

CALENDAR YEAR MAXIMUM: The maximum payable for all Eligible Expenses for each Covered Person shall not exceed in the aggregate the Calendar Year Maximum amount shown in the Schedule of Benefits.

ALTERNATE SERVICES: If two or more services are considered to be acceptable to correct the same dental condition, the Plan will determine service on which payment will be based and the expenses that will be included as Covered Expenses. Benefits payable may be based on the covered expenses for the least expensive service which will produce a professional satisfactory result as determined by the Plan Administrator using guidelines established by the American Dental Association.

PREDETERMINATION OF BENEFITS: Whenever recommended dental treatment is expected to exceed \$200, the Covered Person is encouraged to submit a dental treatment plan to the Third Party Administrator and/or Plan Administrator for review prior to treatment. The dental treatment plan should consist of:

1. A list of the services to be performed, using the American Dental Association nomenclature and codes;
2. A written description of the proposed treatment from the treating Dentist;
3. Supporting pre-treatment x-rays showing the Covered Person's dental needs;
4. Itemized cost of the proposed treatment; and

5. Any other appropriate diagnostic materials requested by the Third Party Administrator.

A predetermination of benefits is not a guarantee of benefits payable. You will be advised if any services are limited or not covered. If you elect a more costly treatment than is determined by the Plan Administrator to be satisfactory for treatment of the condition, payment will be limited to the lesser of the Reasonable and Customary charge of the least costly treatment (subject to any applicable Deductible, Coinsurance and/or Calendar Year Maximum).

When there has not been a predetermination of benefits, the Plan will determine the expenses that will be included as covered expenses at the time the claim is received.

INCURRED DATE OF DENTAL SERVICES: A Dental Services is considered incurred on the date the service, supply, or treatment is started except that service for a prosthetic device will be deemed to start when the prosthetic device is ordered. The term "ordered" means:

1. For fixed bridgework, restorative crowns, inlays or onlays; the date that the first impressions are taken and/or abutment teeth fully prepared;
2. For dentures, the date that the first impressions are taken.

Payment will be made when services are complete.

ELIGIBLE DENTAL EXPENSES

Eligible expenses will include only those expense incurred for such charges when the dental service is performed by or under the direction of a Dentist; is essential for the necessary care of the teeth; and starts and is completed while the person is covered under this Plan.

Any portion of charges for a dental service that exceeds the maximum shown in the Schedule of Dental Benefits is not included.

ELIGIBLE PREVENTIVE CARE EXPENSES: Eligible Preventive Care expenses include the following services:

1. Oral examinations limited to one (1) per person in any six (6) consecutive months.
2. Routine prophylaxis (cleaning), scaling, polishing, and examination, limited to one in any six (6) consecutive months.
3. Topical application of fluoride, limited to one in any six (6) consecutive month period, for Covered Persons under age eighteen (18). Prophylaxis in connection with fluoride treatment is a separate dental service. Allowance includes examination and prophylaxis.
4. X-Rays:
 - a. Full mouth series of at least 14 films, including bitewings if needed limited to once in any thirty-six (36) consecutive months;
 - b. Bitewing x-rays, limited to four (4) films in any six (6) consecutive months;
 - c. Intraoral periapical or occlusal x-rays-single films;
 - d. Extraoral x-rays, superior or inferior maxillary film;
 - e. Panoramic film, maxilla and mandible, limited to one examination in any six (6) consecutive months.
5. Emergency care and palliative treatment for relief of dental pain. Expense incurred is payable as a separate benefit only if no other service was rendered during the same visit. (Any x-ray taken in connection with such treatment is a separate dental service).
6. Space Maintainers for children under age 16, for the initial appliance only. Allowance include all adjustments to the space maintainers within the first six months after installation.

7. Fixed and removable appliances to inhibit thumbsucking and other harmful habits, limited to Dependent children under the age of sixteen (16) and limited to the initial appliance only. Allowance includes all adjustments in the first six (6) months after installation.

ELIGIBLE BASIC SERVICES: Eligible Basic Expenses include the following services:

1. Diagnostic consultation with a dentist other than the one providing treatment, limited to one consultation for each dental specialty in any twelve (12) consecutive months. Benefits are payable for this service only if no other service is rendered during the visit.
2. Diagnostic casts.
3. Biopsy and examination of oral tissue.
4. Restorative dentistry; multiple restorations on one surface will be considered one restoration:
 - a. Fillings of amalgam;
 - b. Synthetic restorations; fillings of silicate, acrylic, plastic, or composite resin;
 - c. Crowns; acrylic or plastic without metal; or stainless steel;
 - d. Pin retention, exclusion of restorative material;
 - e. Recementation; inlay or onlay, crown and bridge.
5. Endodontic services (treatment of disease within a tooth, including root canal). Allowance include routine x-rays and cultures, but excludes final restoration:
 - a. Pulp capping, direct;
 - b. Root canal therapy of non-vital (nerve-dead) teeth. Traditional therapy, Medicated past therapy, N2 Sargenti;
 - c. Vital pulpotomy;
 - d. Apicoectomy (removal of part of the tooth root), as a separate procedure or in conjunction with other endodontic procedures;
 - e. Apexification;
 - f. Remineralization (Calcium Hydroxide), as a separate procedure.
6. Periodontic services (treatment of diseases of the gums and tissues of the mouth). Allowance includes the treatment plan, local anesthetics and post-surgical care:
 - a. Gingivectomy or gingivoplasty, per quadrant;
 - b. Gingivectomy per tooth (fewer than six (6) teeth);
 - c. Sub-gingival curettage and root planing, per quadrant, limited to a maximum of four quadrants in any twelve (12) consecutive months;
 - d. Pedicle or free soft tissue grafts including donor sites;
 - e. Osseous surgery including flap entry and closure, per quadrant;
 - f. Osseous grafts including flap entry, closure and donor sites;
 - g. Muco-gingival surgery;
 - h. Occlusal adjustment not involving restorations and done in conjunction with periodontic surgery, per quadrant, limited to a maximum of four (4) quadrants in any twelve (12) consecutive months.
7. Oral Surgery – allowance includes routine x-rays, the treatment plan, local anesthetics and post surgical care:
 - a. Simple extraction, one or more teeth;
 - b. Surgical removal of erupted teeth, involving tissue flap and bone removal;
 - c. Surgical removal of impacted teeth;
 - d. Alveolectomy, per quadrant;
 - e. Stomatoplasty with ridge extension, per arch;
 - f. Excision of pericoronal gingiva, per tooth;
 - g. Removal of cyst or tumor;
 - h. Incision and drainage of an abscess;
 - i. Closure of salivary fistula;
 - j. Dilation of salivary duct;
 - k. Sequestrectomy for osteomyelitis or bone abcess, superficial;
 - l. Maxillary sinusotomy for removal of tooth fragment or foreign body;

8. Prosthodontic Services – specialized techniques and characterization are not covered:
 - a. Denture repairs, acrylic – repairing dentures, no teeth damaged; repairing dentures and replacing one or more broken teeth; and/or replacing one or more broken teeth, no other damage;
 - b. Denture repairs, metal – allowance based on the extent and nature of damage and on the type of materials involved;
 - c. Denture duplication, jump case limited to once per denture in any thirty-six (36) consecutive months;
 - d. Denture relines, limited to once per denture in any twelve (12) consecutive months. Office relines, cold cure, laboratory relines;
 - e. Denture adjustments, limited to adjustments by a dentist other than the one providing the denture and adjustments more than six (6) months after initial installation;
 - f. Tissue conditioning, limited to a maximum of two (2) treatments per arch in any twelve (12) consecutive months;
 - g. Adding teeth to partial dentures to replace external natural teeth;
 - h. Repairs to crowns and bridges. Allowance based on the extent and nature of damage and the type of material involved.
9. General anesthesia in conjunction with surgical procedures only;
10. Injectable antibiotics needed solely for treatment of a dental condition.

ELIGIBLE MAJOR SERVICES: All services will be paid on the date of completion. Eligible Major Expenses include the following services:

1. Restorative services (crowns, inlays and onlays). Cast restorations and crowns are covered only when needed because of decay or injury, and only when the tooth cannot be restored with a routine filling material.:
 - a. Inlays;
 - b. Onlays, in addition to inlay allowance;
 - c. Crowns and abutments;
 - Acrylic with metal;
 - Precious (full or $\frac{3}{4}$ -cast), semi-precious, or non-precious (full cast) metal, other than stainless steel;
 - Porcelain or porcelain fused to metal;
 - Cast post and core, in addition to crown (not a thimble coping);
 - Steel post and composite or amalgam core, in addition to crown;
 - Cast dowel pin (one piece cast with crown). Allowance based on type of crown.
2. Prosthodontic Services – specialized techniques and characterizations are not covered.
 - a. Fixed bridges – each abutment and each pontic makes up a unit in a bridge;
 - b. Bridge abutments – see inlays and crowns under Major Services;
 - c. Bridge pontics;
 - d. Cast metal, sanitary;
 - e. Plastic or porcelain with metal;
 - f. Slotted facing;
 - g. Slotted pontic;
 - h. Simple stress breakers, per unit;
 - i. Removable bridges, unilateral partial, one piece chrome casting, clasp attachment, including pontics.
3. Dentures – includes all adjustments done by the dentist furnishing the denture in the first six months after installation.
 - a. Full dentures, complete or immediate, upper or lower;
 - b. Partial dentures, including base, all clasps, rests and teeth;
 - Upper, with two chrome clasps with rests, acrylic base;
 - Upper, with chrome palatal bar and clasps, acrylic base;
 - Lower, with two chrome clasps with rests, acrylic base;
 - Lower, with chrome lingual bar and clasps, acrylic base;
 - Stay plate, upper or lower (anterior teeth only).

ORTHODONTIA EXPENSES: Benefits for orthodontic services are paid up to the maximum shown in the Schedule of Dental Benefits, for dependent children who are less than nineteen (19) years old when the active appliance is first placed.

The Lifetime Deductible, as shown in the Schedule of Dental Benefits, is the amount of eligible Orthodontia Expenses which must be incurred by each Covered Person (if applicable) before any benefits are payable. These charges must be incurred while the eligible dependent is covered under this Plan. Charges used to meet this deductible cannot be used to meet the deductible which applies to other services.

Once the Lifetime Deductible is met, eligible services will be payable. Using the treatment plan, the total benefit payable will be calculated, then divided into equal payments which will be distributed over the lesser of two years or the proposed length of treatment.

The initial payment will be made when the active appliance is first placed. Further payments will be made at the end of each subsequent three (3) month period. However, treatment must continue and the patient must remain a covered person under this Plan.

The following are covered expenses for Orthodontic services:

- Any Class I, II or III service furnished in connection with orthodontic treatment;
- Surgical exposure of impacted or un-erupted teeth in connection with orthodontic treatment, including routine x-rays, local anesthetics and post-surgical care;
- Active appliances (all types), including diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.

Although diagnostic procedures are included as part of orthodontic coverage, the course of orthodontic treatment begins when the first orthodontic band or appliance is inserted and ends when the last band or appliance is taken off.

DENTAL EXCLUSIONS AND LIMITATIONS

No benefits are payable for the following under the dental Plan.

1. Any service that is considered cosmetic dentistry, including, but not limited to, characterizing and personalizing prosthetic devices and making facing on prosthetic devices for any teeth in back of the second bicuspid;
2. Porcelain or acrylic veneers of crowns or pontics on or replacing teeth other than the ten upper and lower anterior teeth;
3. Preventive control programs including, but not limited to: oral hygiene instructions, plaque control, fissure sealants, or dietary planning;
4. Fees for services rendered by someone other than a licensed Dentist or auxiliary personnel under the Dentist's direct supervision, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed Dental Hygienist. The treatment must be rendered under the direct supervision and guidance of the Dentist in accordance with generally accepted dental standards;
5. Any services or supplies provided for Inpatient or Outpatient Hospital care; for a surgical treatment facility;
6. Any services or supplies that are in any way paid or entitled to payment by or through a public program, other than Medicaid;
7. Any service which is deemed Experimental in nature, based on standards of the American Dental Association;
8. Treatment which does not meet accepted standards of dental practice, based on standards of the American Dental Association;

9. Replacement of a bridge or denture or addition of teeth to a partial bridge or denture, unless a) such replacement or addition is required to replace one or more teeth extracted after installation; b) the bridge or denture cannot be made usable and it was installed at least five (5) years prior to its replacement; c) the denture is an immediate temporary denture which cannot be made permanent and which is replaced within twelve (12) months after it was installed. If an existing denture can be made usable, but the choice is made to replace the denture, only the amount which would have been required to make the denture usable will be paid.
10. Replacement of a bridge or denture that can be made useable according to dental standards;
11. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance, including replacement or repair of an orthodontic appliance;
12. Treatment an individual receives before coverage starts or after it ends, unless otherwise stated herein;
13. Services to replace a tooth that was missing prior to the effective date of coverage, including congenitally missing teeth, unless a prosthetic device also replaces one or more natural teeth lost or extracted after coverage under the Plan became effective;
14. Services or supplies for which there is no legal obligation to pay, or charges which would not be made but for the availability of benefits under this Plan;
15. Any charge for any condition, disability or expense resulting from or sustained as a result of war or act of war, declared or undeclared;
16. Dental service or supplies received through a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar person or group;
17. Eligible dental benefits or services or prepaid treatment program sponsored or covered by this Employer's Medical Plan;
18. Expenses incurred in connection with any intentionally self-inflicted Injury or Illness;
19. Any expense which exceeds the Reasonable and Customary expense for the care rendered;
20. Any expenses for preparing dental reports or itemized bills;
21. Any expense for professional services performed by a person who ordinarily resides in the Covered Person's household or who is related to the Covered Person, such as a spouse, parent, child, brother, or sister, whether such relationship is by blood or exists in law;
22. Any expenses which would entitle the Covered Person to any benefit under Worker's Compensation Act or similar legislation or which is due to Injury or Illness arising out of or in the course of any occupation or employment for wage or profit;
23. Any expense for care or treatment provided or furnished by the United States Government or in any other Hospital operated by a government of any country if in-service related;
24. Expenses for surgical implants of any type including prosthetic device attached to it;
25. Expenses for procedures or appliances (except full dentures), whose main purpose is to change the vertical dimension, stabilize periodontal involved teeth or restore occlusion, (i.e. occlusal guards, athletic guards, splinting occlusal adjustments), except to the extent that this Plan covers orthodontic treatment, splint or stable teeth for periodontic reasons, replace tooth structure lost as a result of abrasion or attrition and to treat disturbances of the Temporomandibular Joint;
26. Expenses for topical sealants or precision attachments;
27. No payment will be made for expenses incurred for a Covered Person to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a) "no-fault" insurance law; or b) an uninsured motorist insurance law. The Plan will take into account any adjustment option chosen under such part by the Covered Person or their covered dependent.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

COVERAGE PROVIDED UNDER THE PLAN FOR COVERED EMPLOYEES SHALL BE IN ACCORDANCE WITH THE EMPLOYEE'S ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS INCLUDED HEREIN AND COVERAGE CLASSIFICATION (IF ANY) UNDER THE PLAN.

ALL COVERAGE UNDER THE PLAN SHALL BEGIN AT 12:01 A.M. STANDARD TIME, ON THE DATE SUCH COVERAGE IS EFFECTIVE.

BENEFITS AVAILABLE:

Employee and Dependent Coverage: Benefits are offered on a "stand-alone" basis. This means that the Employee may elect coverage for himself and his dependents under one or more of the following benefits: Medical and Prescription Drug benefits; and/or Dental Benefits. Coverage may be waived for one or all of the benefits offered, however, a dependent will only be covered for a particular benefit if the Employee is also covered for that benefit.

EMPLOYEE ELIGIBILITY: An Employee eligible for coverage under the Plan shall include only an Employee who is in an eligible Class and meets the following conditions:

1. is employed by the Employer on a regular basis and who is scheduled to work a minimum of thirty (30) hours per week. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel, and for which he receives regular earnings from the Employer; and
2. has met the required waiting period.

WAITING PERIOD: The Waiting Period is the length of time immediately before your coverage can become effective during which you must be an eligible Employee.

With respect to such an eligible person who becomes employed by the Employer on or after the Effective Date of this Plan, the Waiting Period is: 30 Calendar Days, coverage is effective on the 31st day.

With respect to such eligible person employed by the Employer prior to the Effective Date of this Plan who has not completed the prior plan's waiting period, the Waiting Period is: 30 Calendar Days, coverage is effective on the 31st day, with credit given for days satisfied prior to this Plan's Effective Date.

With respect to such eligible person employed by the Employer prior to the Effective Date of this Plan, who has completed the Waiting Period under the previous Plan, the Waiting Period is: None.

EMPLOYEE ENROLLMENT

INITIAL ENROLLMENT: An eligible Employee's coverage under this Plan shall become effective on the date the Employee has completed the Waiting Period provided he agrees to make any required contribution and makes written application to the Plan Administrator for coverage within thirty (30) days of that date.

SPECIAL ENROLLMENT: If an eligible Employee does not apply for coverage on or before the date he completes the Waiting Period because he had other health coverage as of that date, the Employee's coverage under this Plan will become effective as of:

1. the date the Employee's COBRA continuation coverage has exhausted, if the Employee had coverage under COBRA (exhaustion of a COBRA continuation period means that an individual's COBRA continuation period ceases for any reason other than either 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); or
2. the date the Employee's other coverage terminates as a result of loss of eligibility for coverage as a result of separation, divorce, death, termination of employment or reduction in the number of hours worked; or
3. the date the Employee's other coverage terminates as a result of employer contributions being terminated.

In order for coverage to become effective as of the date the Employee's other coverage has terminated, the Employee must make written application for coverage under this Plan within thirty (30) days of that date. The Employee must provide a certificate of Creditable Coverage as proof of prior coverage.

If an eligible Employee waived coverage under this Plan and makes written application to cover a new spouse, newborn child or an adopted child, the Employee (and his eligible spouse, if applicable) must also make written application for coverage within 30 days of marriage, the child's date of birth or, in the case of adoption, 30 days of the date of the actual adoption or the date of placement for the purpose of adoption. Coverage will become effective for the Employee and such eligible Dependents as of the date of marriage, child's date of birth, or the date of adoption or placement for the purpose of adoption.

LATE ENROLLMENT: If an eligible Employee does not make written application for coverage during the Initial Enrollment period or a Special Enrollment period, that Employee must wait until the Open Enrollment Period to make written application for coverage.

OPEN ENROLLMENT: The Open Enrollment Period will be held each year during the month of September, whereby eligible employees and their dependents will be able to change some of their benefit decisions based upon which benefits are right for them. Benefit decisions made during this period will be effective October 1st and will remain in effect for a year unless there is a change in family status or loss of other coverage. Coverage waiting periods are waived during annual enrollment for eligible employees and eligible dependents. An eligible employee who fails to make an election during the annual enrollment will automatically retain his present coverage. The Pre-Existing Condition Limitation will apply (refer to the section entitled "Pre-Existing Conditions").

TERMINATION OF EMPLOYEE COVERAGE: Coverage shall terminate immediately upon the earliest of the following dates:

1. the date on which employment terminates; or
2. up to the date following sixty (60) days from the date the Covered Employee is temporarily laid-off. Such leave will run concurrently with any approved leave of absence to which the Employee is entitled under the Plan; or
3. up to date following thirty (30) days from the date the Employee begins an approved personal leave of absence if he is not entitled or is no longer entitled to a leave of absence under the Family and Medical Leave Act. Such leave will run concurrently with any other approved leave of absence to which the Employee is entitled under the Plan; or
4. up to the date following thirty (30) days from the date the Employee begins an approved medical leave of absence if he is not entitled or is no longer entitled to a leave of absence under the Family and Medical Leave Act. Such leave will run concurrently with any other approved leave of absence to which the Employee is entitled under the Plan; or
5. up to twelve (12) weeks from the date the Employee begins an approved personal or medical leave of absence under the Family and Medical Leave Act ("FMLA"). Such leave is subject to all provisions of the "FMLA" and will run concurrently with any other approved leave of absence to which the Employee is entitled under the Plan; or
6. the date the Employee ceases to be in a class of Employees eligible for coverage (such as becoming a part-time Employee, being laid-off, or taking an unapproved personal or medical leave of absence) unless the Employee's coverage is continued for a time due to a temporary lay-off, approved personal leave of absence, or approved medical leave of absence; or
7. the end of the period for which an Employee makes his last contribution for coverage, if a contribution is required; or
8. the date the Plan terminates; or
9. the date the Employee dies; or
10. the date the Employee becomes a full-time member of the Armed Forces of any country. However, if a Covered Employee temporarily leaves the Employer because of military service, the applicable provisions of the Uniformed Services Employment and Re-Employment Rights Act of 1993 will apply.

EXTENSION OF COVERAGE FOR DISABLED EMPLOYEES: Under some conditions, coverage under the Plan may be extended beyond the normal termination of coverage date due to disability. Coverage may continue for an Employee and their dependents for a period of 90 days.

REINSTATEMENT OF COVERAGE: The Waiting Period will be waived for an eligible Employee (and any of his eligible dependents who were covered under the Plan) if the Employee's coverage terminates after the expiration of an extension of coverage due to being laid off, being granted an approved leave of absence and he is rehired within a six (6) month period immediately following the date his coverage terminated under this Plan. The provision for Pre-Existing Conditions will not apply to the Employee (and any of his covered dependents) as of the date they become effective under the Plan again. Expenses incurred during the time the individual (or any eligible dependent) was not covered under the Plan will not be eligible for benefits under the Plan.

An Employee's coverage under the Plan (and that for his eligible dependents, if previously covered) will become effective on the day he returns to work as an eligible Employee if he agrees to pay any required contribution and applies for coverage for himself (and his dependents, if applicable) within thirty (30) days of that date.

All other "Eligibility, Effective Date and Termination" provisions as shown in this section will apply.

DEPENDENT ELIGIBILITY: Eligible Dependents are:

1. the Employee's legal spouse (as determined by the State in which the Employee resides), except an Employee's spouse who is employed and is eligible for group coverage under this Plan, can only be covered if the spouse accepts the coverage offered by their Employer. The Spouse is required to take coverage for themselves and on any children if the spouse's birthday comes first in the Calendar Year for this Plan to be cover as secondary. Coverage for the children, by the spouse, is not required if the birthday of the Employee covered under this Plan comes first in the Calendar Year. However, if the spouse's medical health care coverage premium for minimal health coverage exceeds \$125 per month, then they may pay an alternate premium amount of \$200 per month to be on this Plan.
2. the Employee's child who meets all of the following conditions:
 - a) is a resident of the same country in which the Employee resides; and
 - b) is unmarried; and
 - c) is not employed on a regular full time basis; and
 - d) is a natural child; legally adopted child; stepchild who qualifies as a dependent on the Employee's federal income tax return; or a child who has been placed under the legal custody or guardianship of Employee; and
 - e) is a child who is up to the limiting age. The "*limiting age*" is up to the end of the month in which the child reaches nineteen (19) years of age, unless a full time student, then up to the end of the month in which the child reaches age twenty-five (25) years of age.

Coverage for adopted children begins on the earlier of: the date of the actual adoption; or the date of placement for the purpose of adoption and is continuing unless the placement is disrupted prior to legal adoption of the child.

Coverage for children who have been placed under the Employee's legal custody or guardianship will begin on the date the Employee files for legal custody or guardianship unless legal custody or guardianship is not granted to the Employee.

COVERAGE REQUIRED BY A "QUALIFIED MEDICAL CHILD SUPPORT ORDER": Any requirement that would disqualify a dependent from being eligible under the Plan will be waived if the Plan has been issued a "qualified medical child support order" by a court of law for a dependent of a Covered Employee or of a Covered spouse. To be considered "qualified", the following information must be included in the order:

1. the name and last known mailing address of the Covered Person and each child to be covered.
2. a reasonable description of the type of coverage to be provided by the plan to each child or the manner in which the type of coverage is to be determined.
3. the period to which the order applies.

4. each plan to which the order applies.

In order for the child's coverage to become effective as of the date the court order has been issued, the Employee must apply for coverage within the time periods specified under the section entitled "Dependent Enrollment".

COVERAGE REQUIRED BY A "NATIONAL MEDICAL SUPPORT NOTICE": Any financial dependency requirement or residency requirement that would disqualify a dependent from being eligible under the Plan will be waived if the Employer has been issued and receives an "appropriately completed" "National Medical Support Notice" by a court or by a State child support agency for a dependent of a non-custodial eligible Employee, provided the notice is qualified.

An "appropriately completed" notice must contain:

1. the name of an Issuing Agency;
2. the name and last known mailing address of an Employee who is a Covered Person or who is eligible for participation under the Plan, who is a non-custodial parent obligated by a State court or administrative order to provide medical child support for one or more children named in the Notice;
3. the name and mailing address of one or more alternate recipient(s) (an "alternate recipient" means any child of a Covered Person or an eligible Employee who is recognized under a medical child support order as having a right to enrollment under the Plan) or the mailing address of a substituted official or agency; and
4. the family group health care coverage required by the child support order is identified and available.

If the Employer receives a "National Medical Support Notice" for a dependent of a non-custodial Employee, who is an eligible Employee as defined by the Plan, and such notice is determined to be "appropriately completed" by the Plan Administrator, then the notice will be considered to be a "Qualified Medical Child Support Order" which will be recognized by the Plan and such dependent will become eligible under this Plan.

If a "National Medical Support Notice" is determined to be a qualified notice, then, in accordance with the ERISA and the Child Support Performance and Incentive Act:

1. If the eligible Employee, who is the non-custodial parent, is not enrolled for coverage under the Plan, then such Employee must enroll for Employee and dependent coverage (for the applicable dependent) under the Plan. Coverage for the eligible Employee and his applicable dependent(s) will become effective on the date the order is issued, if the Plan Administrator deems the notice is qualified; such Employee must complete an enrollment form.
2. If the Employee is covered under the Plan prior to the date of the order, then the dependent child's coverage will become effective as of the date the order has been issued; the Employee must apply for coverage for such dependent.
3. If Employee contributions are required for coverage under this Plan, then the Employer must withhold the necessary contributions for coverage from the Employee's paycheck, if it is determined that Federal or State (of the Employee's principal place of employment) withholding limitations or prioritization rules permit the withholding. An Employee may contest the wage withholding; the Employee should contact the agency that issued that order.
4. If the Plan has an "Open Enrollment" provision, then such provision will not apply to the Employee nor will it apply to the applicable dependent.
5. Coverage of a dependent child because of qualified "National Medical Support Notice" will terminate on the earlier of: a) the date the court or administrative child support order is no longer in effect; b) the date the Employer cannot withhold a sufficient amount of the required Employee contributions (if any) because of income withholding limitations; c) the date the child has comparable coverage in effect through another group or individual plan (other than a government-sponsored plan, such as Medicare or Medicaid); or d) the date coverage would end for similarly situated dependents.

This Plan will not provide any type or form of benefit, or any option, not otherwise provided under the Plan and all other eligibility, effective date and termination provisions will apply. The Pre-Existing Condition Limitation, as defined herein, will also apply.

This Plan will not provide any type or form of benefit, or any option, not otherwise provided under the Plan and all other dependent eligibility, effective date and termination provisions will apply.

COVERAGE FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN: The age requirement above is waived for any mentally or physically handicapped child who is covered under this Plan, provided that the child is incapable of self-sustaining employment and is chiefly dependent upon the Employee for support and maintenance beginning prior to the date on which the dependent reaches the limiting age. You must provide proof of incapacity and dependence to the Plan Administrator within ninety (90) days of the date on which the limiting age is attained. Additional proof may be required from time to time.

In the event the child is no longer mentally or physically handicapped, then such extension of coverage will terminate within thirty (30) days of the date the child is declared no longer mentally or physically handicapped by a Physician.

DEFINITION OF A "FULL-TIME STUDENT": A "Full-Time Student" is an Employee's dependent child who is enrolled in and regularly attending an accredited college, university, or trade school for the minimum number of credit hours required by that college, university, or trade school in order to maintain full-time student status. A "Full-Time Student" will remain eligible under the Plan during summer break even if temporarily employed on a full-time basis. Coverage will terminate at the end of the summer break if the dependent is not enrolled in and regularly attending school on a full-time basis as of the beginning of next regular session, semester or term.

THOSE PERSONS SPECIFICALLY EXCLUDED FROM THE DEFINITION OF A DEPENDENT ARE:

1. any person on active military duty; or
2. any person eligible for coverage under this Plan as an individual Employee except that:
 - a) when both husband and wife are covered as Employees under this Plan, only one may cover dependent children and either spouse may elect to be covered as a dependent spouse for coverage;
 - b) when the person is also an eligible dependent under this Plan, the person may be covered as an individual Employee or an eligible dependent, but not as both; or
3. any person who is covered as a dependent by more than one Employee of the same Employer may be eligible as a dependent under only one Employee.

If a person is eligible to be covered under the Plan as an Employee and as an eligible dependent child and has elected to be covered as a dependent, that person will, upon reaching the limiting age for a dependent, be automatically covered as an Employee. The Waiting Period will be waived and credit will be given under the Pre-Existing Condition limitation for any periods of Creditable Coverage previously satisfied as a covered dependent under the Plan.

The dependent benefits provided under the Plan for a Covered Employee shall be in accordance with the Dependent Eligibility, Effective Date and Termination Provisions included herein and his coverage classification (if any) under the Plan.

DEPENDENT ENROLLMENT

INITIAL ENROLLMENT: If you are an Employee who agrees to pay any required contribution, your eligible dependent(s) will become covered on the latest of the following dates:

1. your effective date providing you make written request for dependent coverage during the time periods specified under the section entitled "Employee Initial Enrollment; or
2. the date the dependent meets the definition of an "Eligible Dependent" if you make written application for dependent coverage on or before the 30th day after the date your dependent becomes eligible.

SPECIAL ENROLLMENT: If you are an eligible Employee who applies for Dependent coverage after thirty (30) days because your eligible Dependent(s) had other health coverage as of the date coverage under this Plan would have otherwise become effective, the Dependent's coverage under this Plan will become effective as of:

1. the date the Dependent's COBRA continuation coverage has exhausted, if the Dependent had coverage under COBRA (exhaustion of a COBRA continuation period means that an individual's COBRA continuation period ceases for any reason other than either 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); or
2. the date the Dependent's other coverage terminates as a result of loss of eligibility for coverage as a result of separation, divorce, death, termination of employment or reduction in the number of hours worked; or
3. the date the Dependent's other coverage terminates as a result of contributions being terminated.

In order for coverage to become effective as of the date the eligible Dependent's other coverage has terminated, the Employee must make written application for Dependent coverage under this Plan within thirty (30) days of that date. The Employee must provide a certificate of Creditable Coverage as proof of prior coverage for such eligible Dependents.

If you are an eligible Employee who waived coverage under this Plan and you make written application to cover a new spouse, newborn child or an adopted child, you (and your eligible spouse, if applicable) must also make written application for coverage within 30 days of marriage, the child's date of birth or, in the case of adoption, 30 days of the date of the actual adoption or the date of placement for the purpose of adoption. Coverage will become effective for you and such eligible Dependents as of the date of marriage, child's date of birth, or the date of adoption or placement for the purpose of adoption.

LATE ENROLLMENT: If you are an eligible Employee who does not make written application for Dependent coverage during the Initial Enrollment period or a Special Enrollment period, you must wait until the Open Enrollment Period to make written application for coverage.

TERMINATION OF DEPENDENT COVERAGE: A Dependent's Coverage shall automatically terminate immediately upon the earlier of the following dates:

1. the earlier of: the date on which a divorce is granted from the Employee for a Dependent spouse; or, the date on which a legal separation is granted from the Employee for a Dependent spouse; or
2. the date a dependent child ceases to meet the definition of an eligible dependent under the Plan; or
3. the date coinciding with termination of the Employee's coverage under the Plan; or
4. if an Employee fails to make a required contribution for dependent coverage, the end of the period for which the Employee made his last required contribution; or
5. the date the Plan is terminated; or with respect to any dependent's benefit of the Plan, the date of termination of such benefits; or
6. the end of the month from the date the Employee dies.

In order for any dependent whose coverage is terminated to be eligible for continuation of coverage under "COBRA", the Employee must notify the Plan Administrator within 60 days of the date the dependent is no longer eligible for coverage under the Plan.

CHANGES IN BENEFITS OR ELIGIBILITY PROVISIONS (APPLIES TO COVERED PERSONS): If there is a change in the benefits or eligibility provisions under the Plan, expenses incurred on or after the effective date of the change will be payable in accordance with the amended plan provisions.

FAMILY AND MEDICAL LEAVE ACT

ELIGIBLE EMPLOYEES: You will be eligible for an extension of benefits under the Family and Medical Leave Act if you are covered under this Plan and have worked for the Employer for at least 12 months and 1,250 hours in the 12 months immediately preceding the start of your leave of absence. (The 12 months of service need not be consecutive. Each partial week on the payroll is counted as one week, and 52 weeks are considered as 12 months.)

Whenever possible, you must try to set up your leave schedule so as not to disrupt the Employer's operations.

During a qualified leave of absence, you will be subject to the same benefits and plan provisions as active Employees.

QUALIFYING EVENTS: The following situations will qualify you for an extension:

1. Birth or adoption of a child by the Employee or the Employee's spouse; or
2. Placement in the Employee's or Employee's Spouse's care of a foster child; or
3. The Serious Illness of an Employee's spouse, child or parent; or
4. Your own disabling Serious Illness.

SERIOUS ILLNESS: "*Serious Illness*", as it applies to the Family and Medical Leave Act, means an illness, injury, impairment, or physical or mental health condition involving a period of incapacity and/or either In-Patient care or "continuing treatment by a health care provider", or requiring absences on a recurring basis or for more than three days for treatment or recovery.

NOTICE TO THE EMPLOYER: You must give 30 days' advance notice to the Employer of your need for a leave of absence. In cases when advance notice is not possible (i.e., a premature birth or accident), you must give notice to the Employer as soon as you can: ordinarily this should be within two business days of the date of the event.

You must give the Employer the following information at that time:

1. the reason for the leave; and
2. the date you will begin your leave of absence; and
3. how long you expect to be on leave.

If an emergency exists where it is not possible for you to notify the Employer, your spouse or other family member may provide such notice.

If you do not give the Employer adequate notice of a leave of absence, the Employer has 30 days from the date you notify him to deny your leave of absence

MEDICAL CERTIFICATION: If you are seeking leave due to a Serious Illness, the Employer may require you to obtain certification from your attending Physician that you are disabled due to a serious health condition. If the Employer requests such certification you must provide it, at your own expense, within 15 calendar days of his request. The Employer may also require, at his expense, a second opinion and, if the first two opinions disagree, a third medical opinion.

If your leave is foreseeable and you do not provide the Employer with such notification within the time limit shown above, the Employer may deny your leave of absence until you do provide certification.

The Employer may also require re-certification of medical necessity every 30 days (but not less than 30 days from the last certification) or if there is a change in your medical condition or if he receives information questioning the validity of the most recent certification.

If the leave is for your own illness, the attending Physician must certify that you are unable to perform any work or to perform the essential functions of your own job.

If the leave is for the illness of your spouse or other eligible family member, you must certify the care you will be providing to that family member and the family member's attending Physician must certify the need for such care.

INTENT TO RETURN TO WORK: While you are on leave, the Employer may require you to provide periodic reports to him regarding your status and your intent to return to work.

CONTRIBUTIONS: If you are required to make a contribution for coverage as an active Employee and this is an unpaid leave of absence, you and the Employer must work out, in advance, an acceptable method of payment for your contributions during your leave. Once the method of payment has been established, the Employer must provide you, in advance, a written notice of the terms and conditions of such payments. During your leave, your contribution may not be more than what you would have paid as an active Employee.

If you do not make any agreed upon payment within 30 days after the date it is due, the Employer may terminate your coverage at the end of the 30-day "grace period".

If the Employer determines that you will not be returning to work after your leave of absence (i.e., you are not seriously ill and you did not return to work and continue to work for at least 30 calendar days), the Employer may recover the full cost of coverage from you. The "full cost of coverage" is the amount that COBRA continuees are charged less the 2% administration fee.

MAXIMUM LENGTH OF EXTENSION: If you work 30 or more hours per week and are eligible for an approved leave of absence under the Family and Medical Leave Act you may take up to 12 weeks of leave in any 12-month period. This 12-month period will be determined by the Employer (i.e., it may be a Calendar Year or a fixed 12-month period). The Employer must notify you 60 days in advance of any change made to the term of the 12-month leave period.

If the reason for the approved leave of absence is the birth or adoption of a child by you or your spouse or placement in your or your spouse's care of a foster child, your entitlement to the 12-week leave of absence ends 12 months after the date of birth or placement.

If maternity is the reason for the approved leave of absence, periods taken for medical disability and periods taken as a personal leave of absence both count towards the 12-week maximum extension. (For example, if you take 6 weeks of leave due to medical disability, only 6 more weeks remain for the personal leave of absence.)

If you work less than 30 hours per week or have variable hours and are eligible for an approved leave of absence under the Family and Medical Leave Act, the leave entitlement is calculated on a prorated or proportional basis. (For example, if you are a part-time Employee and work 10 hours per week, you will be entitled to a 4-week extension. If you work variable hours, your leave will be based on the average weekly hours worked in the 12 weeks prior to the start of your leave of absence.)

If you and your spouse work for the same Employer, the combined maximum amount of leave you may both take under the following conditions is 12-work-weeks during any 12-month period:

1. the birth or adoption of a child; or
2. placement in your care of a foster child; or
3. the serious health condition of a parent.

CHANGES IN COVERAGE AND/OR BENEFITS: While you are on an approved leave of absence, you may make coverage changes, such as adding coverage for a newborn child, on the same basis as if you were an Active Employee and any changes made to the Plan's benefits or eligibility provisions while you are on an approved leave of absence will apply to you and your dependents on the same basis as any other Covered Person.

RETURNING TO WORK: You will continue to be covered under the Plan on the same basis as any other Covered Person as long as you return to work for the Employer before the maximum length of time for the approved leave of absence has expired.

EMPLOYEE'S RIGHTS: The Employer may not in any way interfere with your rights under the Family and Medical Leave Act or discriminate against you if you either file charges or provide information or testimony against the Employer for alleged violations of the Family and Medical Leave Act. The basis for this is Title VII of the Civil Rights Act of 1964.

CONTINUATION OF COVERAGE (COBRA)

BENEFITS MAY BE EXTENDED UPON REQUEST FOR COVERED EMPLOYEES AND/OR THEIR COVERED DEPENDENTS IF QUALIFIED PER ONE OF THE FOLLOWING "QUALIFYING EVENTS":

EMPLOYEE: For a Covered Employee to be qualified, the Covered Employee must become ineligible for group coverage because of termination of employment (other than because of gross misconduct), because of reduction in the number of hours worked, or the Employer filing for reorganization under Chapter XI of the Bankruptcy Law.

DEPENDENT: For a covered spouse or covered child to be qualified, they must become ineligible for group coverage because of one of the following:

1. Death of the Employee;
2. Termination of the Employee's employment (other than because of gross misconduct) or reduction in the number of hours of employment;
3. Divorce or legal separation;
4. The Covered Employee becoming "entitled to" Medicare benefits;
5. A dependent child ceasing to meet the definition of "dependent";
6. The Employer files for reorganization under Chapter XI of the Bankruptcy Law.

The Covered Person must notify the Plan Administrator within 60 days of either of these events that his spouse or children are no longer eligible Dependents. For all other qualifying events, the Employer must notify the Plan Administrator within 30 days of the event. The Plan Administrator must then notify the qualified beneficiary of his or her right to continue during the next 14 days.

The term "*Qualified Beneficiary*" is a Covered Employee and/or the spouse or child of a Covered Employee, who on the date immediately before a qualifying event occurred, was covered for benefits under this group health Plan. Also, a qualified beneficiary is a child who is born to or placed for adoption with the Covered Employee during the period of continuation of coverage (COBRA).

The continuation coverage will be identical to the coverage provided under the Plan to similarly situated persons who have not experienced a qualifying event. The qualified beneficiary does not have to provide evidence of good health to continue coverage, nor will such person be required to satisfy a new Pre-Existing Condition Limitation, as defined herein.

Each qualified beneficiary can elect coverage independently. Benefits under the Plan will be offered on the same basis as it is to Active Employees and their covered dependents. For example, if medical coverage, dental coverage and vision coverage are offered to Active Employees as a "package", the qualified beneficiary can elect coverage as a package or elect medical coverage only. If medical coverage, dental coverage and vision coverage are offered to Active Employees as separate options, the qualified beneficiary can elect such coverage as separate options.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), is intended to make it easier for an individual who has or has had health coverage to become covered by a new employer's health plan even if the employee (or covered spouse or dependent) has a Pre-Existing Condition. Group health plans must comply with all HIPAA pre-existing condition requirements and crediting of prior health coverage requirements at the beginning of the first plan year starting after June 30, 1997.

Under HIPAA, credit will be given for continuous health coverage under this Plan (including COBRA) to reduce, month for month, the new employer's plan's pre-existing conditions exclusions providing: 1) the individual has not had a break in coverage which exceeds sixty-two (62) days (excluding the new employer's plan's waiting period; it is not considered a break in coverage); and 2) the individual makes written application for coverage within the time periods specified under the new employer's plan; and 3) provides the new employer with the necessary documentation to certify the individual's prior coverage. If there is a break in coverage of sixty-three (63) days or more, the pre-existing conditions exclusion under the new employer's plan's will apply to that individual; the plan is not required to give pre-existing limitation credit for prior coverage when there is a break of sixty-three (63) days or more.

The employee should check with his/her new employer to see when the new employer's plan year begins and to find out what the pre-existing conditions requirements are for that plan.

If coverage has terminated under this Plan and the individual purchases individual coverage, he/she should check with the insurance company to find out if he/she is eligible for credit for continuous coverage for pre-existing conditions.

If coverage has terminated under this Plan, the Third Party Administrator will provide a certificate of Creditable Coverage to the Covered Person(s) who terminated coverage under this Plan.

WHEN MUST I ELECT COBRA COVERAGE? The Covered Person must elect coverage within 60 days of the latest of the following dates: The date coverage terminates or the date shown on the Plan Administrator's notice of the right to elect continuation.

If Continuation of Coverage is elected, the qualified beneficiary is required to pay a premium for his/her continuation coverage. This premium generally equals the Employer's cost of providing coverage for similarly situated beneficiaries, plus a two (2%) percent fee for administrative costs.

IF CONTINUATION OF COVERAGE IS ELECTED, PREMIUMS ARE DUE FROM THE QUALIFIED PERSON AS FOLLOWS:

1. The first premium payment(s) may be deferred. However, such deferred payment period cannot exceed the 45-day period immediately following the date you send the election form to the Plan Administrator.
2. Payment for any subsequent month of continued coverage must be paid as of the premium due date.
3. If payment is not made by the premium due date there is a 31-day grace period for such payment. If the premium is not paid during that 31-day period, continued coverage will terminate as of the end of the last date for which a premium payment was made.

WHEN WILL COVERAGE FOR QUALIFIED EMPLOYEES END?

1. The date on which coverage ceases under the Plan due to failure to make the required premium, in full, on time; or
2. The date the qualified Employee becomes covered, after electing Continuation coverage under this Plan, under any other health plan which does not impose a "pre-existing condition exclusion clause" (which limits or excludes coverage) or the date any "pre-existing condition clause" under any other group health plan no longer limits or excludes coverage on a pre-existing condition; or
3. The end of 18 months from the date the Continuation began if Continuation was due to the Employee becoming ineligible for group benefits, due to termination of employment, or reduction of hours; or
4. The date that the qualified Employee becomes "entitled to" Medicare benefits (under Part A, Part B, or both) after electing continuation coverage under this Plan; or
5. The date on which the Group Plan is terminated in its entirety.

WHEN WILL COVERAGE FOR QUALIFIED DEPENDENTS END?

1. The date on which coverage ceases under the Plan due to failure to make the required premium, in full, on time; or
2. The date the qualified dependent becomes covered, after electing Continuation coverage under this Plan, under any other group health plan which does not impose a "pre-existing condition clause" (which limits or excludes coverage) or the date any "pre-existing condition exclusion clause" under any other group health plan no longer limits or excludes coverage on a pre-existing condition; or
3. The end of 18 months from the date the Continuation began if Continuation was due to the Employee becoming ineligible for group benefits due to termination of employment or reduction of hours; or
4. The end of 36 months from the date the Employee becomes "entitled" to Medicare benefits (under Part A, Part B, or both) after electing Continuation coverage under this Plan, but not less than the end of 18 months from the date the Continuation began; or
5. The end of 36 months from the date the Continuation began if Continuation was for other qualifying reasons; or

6. The date that the qualified dependent becomes "entitled to" benefits (under Part A, Part B, or both) after electing Continuation coverage under this Plan; or
7. The date on which the Group Plan is terminated in its entirety.

EXTENSION OF THE LENGTH OF COBRA CONTINUATION COVERAGE: If you elect Continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or if a second qualifying event occurs. You must notify the Plan Administrator, in writing, within 60 days of a disability or a second qualifying event in order to apply to extend the period of Continuation coverage. Failure to provide written notice within the 60-day period may affect the right to extend the period of Continuation coverage.

SPECIAL PROVISIONS FOR A TOTALLY DISABLED BENEFICIARY: A disabled qualified beneficiary may elect to extend existing COBRA coverage for himself and for his covered spouse and/or covered dependents, from 18 months up to 29 months provided all of the following conditions are met:

1. the qualified beneficiary's COBRA continuation coverage is due to the Covered Employee's loss of coverage under this Plan because of termination of employment (other than gross misconduct) or due to a reduction in the number of hours worked;
2. the qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled; and, the disability must have started at some time before the 60th day of COBRA Continuation coverage and the disability must be ongoing at least until the end of the 18-month period of Continuation coverage;
3. the qualified beneficiary must give the Plan Administrator a copy of the Social Security disability determination notice within sixty (60) days of the latest of the following dates: a) date of the SSA's disability determination; b) date of the qualifying event; c) date on which the qualified beneficiary would lose coverage under the Plan; or d) date on which the qualified beneficiary is informed of the obligation to provide the disability notice through the Plan's summary plan description or through the initial COBRA Continuation notice provided by the Employer;
4. the qualified beneficiary must provide a copy of the Social Security disability determination notice to the Plan Administrator before the end of the first 18 months of his/her Continuation period; and
5. he/she must notify the Plan Administrator that he/she elects the extension before the end of the first 18 months of his/her Continuation period; he/she must also specify if his/her covered spouse and/or covered dependents elect to extend their coverage. (If the disabled qualified beneficiary is a dependent, also refer to the paragraph entitled "Second Qualifying Event".)

The cost of coverage for months 1 through 18 will be at the rate of up to 102% of the Employer's cost for such coverage; the cost of coverage for months 19 through 29 will be at the rate of up to 150% of the Employer's cost for providing such coverage to similarly situated beneficiaries.

If Social Security determines during the extended 11-month period that the beneficiary is no longer disabled, the beneficiary must notify the Plan Administrator within 30 days of Social Security's final determination. Continuation will then be terminated in the month that begins more than 30 days after the final determination is made by Social Security.

If an extension of the maximum COBRA coverage period is going to be denied, the Plan Administrator must provide you with a written notice of unavailability within 14 days after receiving any notice from a qualified beneficiary that is a notice of a determination of disability. A termination notice will be provided to you as soon as practicable following the Plan Administrator's determination that Continuation coverage shall terminate.

SECOND QUALIFYING EVENT: An 18-month extension of coverage will be available to spouses and to dependent children who elect Continuation coverage if a second qualifying event occurs during the first 18 months of Continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event, but only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan Administrator in writing within 60 days after a second

qualifying event occurs if you want to extend your Continuation coverage. Failure to notify the Plan Administrator in writing within the 60-day period may affect the right to extend the period of Continuation coverage.

If an extension of the maximum COBRA coverage period for a second qualifying event is going to be denied, the Plan Administrator must provide you with a written notice of unavailability within 14 days after receiving any notice from a qualified beneficiary that is a notice of a second qualifying event. A termination notice will be provided to you as soon as practicable following the Plan Administrator's determination that Continuation coverage shall terminate.

Termination Notice: After receiving written notice of a qualifying event, the Plan Administrator must notify you under the following circumstances: 1) if an individual does not qualify for COBRA continuation coverage. A notice explaining why the individual is not entitled to such coverage must be provided to the individual within 14 days of receiving the written notice from the employee or the qualified beneficiary; 2) if COBRA coverage is terminated earlier than the time period for which COBRA Continuation coverage is normally available for the applicable qualifying event. This notice will be provided as soon as administratively practicable after the termination decision is made; it will explain why and when the Continuation coverage was terminated. A HIPAA certificate of creditable coverage will also be provided with this notice.

Trade Act of 2002: The Trade Act of 2002 may extend the COBRA election period, but only if you meet the following requirements related to a job loss: 1) you are receiving trade adjustment, as defined by the Trade Act; 2) you lost group health coverage under this Plan because of the Trade Act; and 3) you did not elect COBRA Continuation coverage under this Plan during the regular COBRA election period for that job loss. If you meet the requirements under the Trade Act shown here, and you were an eligible Employee and you lost coverage because of the Trade Act and did not elect COBRA in the regular 60-day election period for COBRA Continuation under this Plan, then you may qualify for a second 60-day COBRA Continuation period. The new second 60-day COBRA Continuation election period will begin on the first day of the month in which you begin receiving trade adjustment assistance, but only if you make the election within six months after you initially lost group health coverage under this Plan.

COBRA coverage elected during second election period begins on the first day of the new election period. Retroactive coverage for the period from the initial loss of coverage until the first day of the new Trade Act election period will not be provided. If you elect COBRA continuation coverage under this provision, the COBRA maximum coverage period begins on the first day of the additional election period and ends no later than 18, 29 or 36 months thereafter, depending on qualifying events. Any day between your initial loss of group health coverage under this Plan and the first day of your new second election period does not count towards the 63-day break in coverage under HIPAA.

CAN I ADD AN ELIGIBLE DEPENDENT DURING MY CONTINUATION? Any qualified person may elect coverage for a dependent (spouse, newborn child, adopted child, etc.) acquired during a period of continuation. The acquired dependent must be a person who would have been an eligible dependent had he or she been acquired by an active Employee enrolled under the normal terms of the Plan. Qualified persons must apply for coverage for the acquired dependent(s) under the same provision as those in effect for similarly situated Covered Employees. An acquired dependent is a "qualified beneficiary".

CAN I WAIVE COBRA COVERAGE DURING THE ELECTION PERIOD? If a qualified beneficiary signs a waiver of his rights to continuation of coverage during his election period, he cannot revoke his waiver unless he does so within 60 days from the later of: 1) the date coverage terminates; or 2) the date shown on the Plan Administrator's notice of the right to elect continuation.

If the qualified beneficiary revokes the waiver within such time periods shown above: 1) the maximum period of continuation will be the same as it would have been had the individual not waived continuation of coverage; and 2) claims incurred from the date the individual lost coverage to the date the individual revoked the waiver will not be covered under the Plan.

WHAT HAPPENS IF I AM (OR BECOME) INCAPACITATED? If a qualified beneficiary is or becomes physically or mentally incapacitated and cannot waive coverage or make an election to continue coverage for himself/herself within the 60-day election period, then the election period will be tolled (suspended) until a legally-appointed guardian or representative is designated to act on behalf of the qualified beneficiary, providing the guardian or representative is designated within 30 days after the date the qualified beneficiary becomes incapacitated or dies. For example, if the qualified beneficiary becomes incapacitated (or dies) with 10 days remaining in a COBRA election period and the qualified beneficiary has not made an election, then the legally-appointed guardian or representative will have 10 days from the date of his or her appointment to elect the continuation of coverage on behalf of the beneficiary, providing the appointment is within the specified time period.

If the qualified beneficiary elects the continuation of coverage and later becomes incapacitated (or dies) and misses a premium deadline under the continuation of coverage due to the incapacitation, then the deadline for that premium payment will be tolled (suspended) until 30 days from the date a legally-appointed guardian or representative is designated to act on behalf of the qualified beneficiary, providing the guardian or representative is designated within 30 days after the date the beneficiary becomes incapacitated or dies.

CLAIMS INFORMATION

INSTRUCTIONS FOR FILING CLAIMS: You must complete an "Other Coverage Information Form" at the beginning of each Calendar Year. One form should be completed, with information on all Covered Persons in the Employee's family. If the information changes at any time during the Calendar Year (for example, if your spouse has new coverage under another group plan), please complete a new form and submit it to Aultra Administrative Group (AAG). The "Other Coverage Information Form" can be obtained from the Employer; please return the completed form to your Employer. The Employer will retain the original form and fax a copy of the form to AAG.

If a provider does not file the claim with AAG on your behalf, then you are responsible for mailing the itemized copy of the medical bill to the address shown on the back of the Employee Identification Card. An itemized billing includes all of the following information:

- Employer's name
- Employee's name
- Employee's Social Security number
- Patient's name
- Date of treatment
- Type of services or supplies furnished
- Diagnosis
- Procedure codes
- Name, address, and telephone number of the Physician or provider

Canceled checks, cash register receipts, personal itemizations or statements will not give the Third Party Administrator the information needed to process a claim.

**SEND ALL CLAIMS TO:
THE ADDRESS SHOWN ON THE BACK OF YOUR I.D. CARD**

VERIFICATION OF BENEFITS: If you want to verify eligibility and benefits before charges are incurred, please call Aultra Administrative Group at this number: (330) 493-7278 or (800) 325-8424.

VOLUNTARY PREDETERMINATIONS OF BENEFITS: If the Plan does not require approval (pre-certification) of a service or treatment before the service or treatment is rendered, but you voluntarily elect to request a written benefit determination for the proposed service or treatment, then this will be considered an informal inquiry. A claim for benefits does not constitute a Pre-Service claim unless the Plan requires pre-certification for the proposed service or treatment.

TIME LIMIT FOR FILING POST-SERVICE CLAIMS: Affirmative proof of loss for which a Post-Service claim is made must be furnished to the Third Party Administrator within one year of the date the claim was incurred. However, upon termination of the Plan, final claims must be received within sixty (60) days of termination.

TIME LIMITS FOR PROCESSING POST-SERVICE MEDICAL CLAIMS: Upon receipt of a Post-Service medical claim (a claim for services which have already been rendered), the Plan Administrator will furnish a written notice to the Employee with the initial benefits determination (whether the claim is eligible or denied, in whole or in part) within 30 days of receipt of the claim at the Third Party Administrator's place of business. If, for reasons beyond the control of the Plan Administrator, a determination cannot be made at the end of the 30-day period, then an additional period of 15 days will be permitted to make the benefits determination. The benefits determination will be provided on the Explanation of Benefits Form (EOB). If there is insufficient information to make a claim determination within the time periods described, the claim will be denied (an Adverse Benefit Determination) for lack of information; you will be provided a written notification in the EOB or in another written or electronic format. If the claim was denied because there was insufficient information to make a determination, then a description of any additional material or information necessary to make the benefit determination will be provided.

TIME LIMITS FOR FILING CLAIM APPEALS (PRE-SERVICE AND POST-SERVICE CLAIMS): If a claim for benefits is rejected due to lack of information, is denied or if the claim is not paid in full (an Adverse Benefit Determination), the Plan Administrator will specify the reason for any denial or benefit reduction on the Explanation of Benefits Form (EOB) or in another written or electronic format, with reference to the Plan provisions on which the determination was made.

If an initial claim for benefits is either denied, or if the claim is not paid in full (a Post-Service claim), the Covered Person (or an authorized representative, including a health care provider, acting on behalf of the Covered Person) is entitled to make a written request to the Third Party Administrator for access to and copies of all documents, records and other information relevant to the claim; this information will be provided free of charge to the Covered Person (or to the authorized representative). "Relevant" means any document, record, or other information which: 1) was relied upon in making the determination; or, 2) was submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon; or 3) demonstrates compliance with the administrative procedures and safeguards required; or 4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the diagnosis, whether or not such advice or statements were relied upon in making the determination.

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

If the Covered Person, or an authorized representative (including a health care provider acting on behalf of the Covered Person), elects to appeal a claim involving an Adverse Benefit Determination, such appeal must be submitted in writing within 180 days after the Adverse Benefit Determination notice is received. The Covered Person (or an authorized representative of the Covered Person) may submit written comments, documents, records, and other information relating to the claim when making the appeal. Claim appeals submitted after 180 days will be denied, unless the Covered Person was legally incapable of making a written appeal within the 180-day limit, but in no case will the claim appeal be considered if it is submitted one year after the date the notice is received.

The Plan Administrator will review the claim appeal and provide a written decision on the review within sixty (60) days (within thirty [30] days for Pre-Service non-urgent care claims; within 72-hours for Pre-Service urgent care claims) after such request is received. A full and fair review of a claim appeal involving adverse benefit determination is required; the claim appeal must be reviewed by someone other than the individual that denied, in whole or in part, the original claim; the review cannot be conducted by a subordinate of the individual that made the original determination. The review may not rely on the initial Adverse Benefit Determination; it must take into account all comments, documents, records and other information submitted with the claim appeal letter, without regard to whether such information was previously submitted or relied upon in the initial determination.

Prior to adjudicating any appeal which requires a medical judgment be made (for example, Medical Necessity or Experimental Treatment determinations), an appropriate healthcare professional must be consulted; such professional must be someone other than the healthcare professional consulted during the initial processing of the claim. If the Covered Person (or the authorized representative, including a health care provider acting on behalf of the Covered Person) makes a written request for the name of the health care professional(s) consulted by the Plan Administrator in connection with an appeal of an Adverse Benefit Determination involving Medical Necessity, such information must be provided to the Covered Person free of charge.

IF A CLAIM APPEAL IS DENIED: There are two options available if an appeal of an Adverse Benefit Determination is denied:

If the initial claim appeal of an Adverse Benefit Determination is denied (in whole or in part) by the Plan Administrator, the Covered Person (or the authorized representative of the Covered Person) may voluntarily elect an additional level of appeal, including arbitration or any other form of alternative dispute resolution, provided:

- a) the Plan Administrator will not assert a failure to exhaust administrative remedies where a Covered Person elects to pursue a claim in court rather than through the voluntary level of appeal;
- b) the Plan Administrator agrees that any statute of limitations applicable to pursuing the Covered Person's claim in court will be extended (tolled) during the period of the voluntary appeal process;
- c) the voluntary level of appeal is available only after the Covered Person has pursued the initial appeal of an Adverse Benefit Determination;

- d) the Plan Administrator provides the Covered Person with sufficient information (at no cost to the Covered Person) to make an informed judgment about whether to submit a claim through the voluntary appeal process. The Covered Person's decision will have no effect on the individual's rights to any other benefits under the Plan. The rules of the appeal will be provided to the Covered Person. The Covered Person will have a right to representation. The process for the selection of the decision maker for the appeal will be explained and the circumstances, if any, that may affect the impartiality of the decision maker; and
- e) no fees or costs are imposed on the Covered Person as part of the voluntary appeal process.

If the initial claim appeal of an Adverse Benefit Determination is denied (in whole or in part) by the Plan Administrator, then the Covered Person has the right to bring a civil action under section 502(a)(1)(B) of ERISA.

You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office.

INTENT FOR CLAIMS PROCEDURES AND CLAIMS APPEALS: It is the Plan Administrator's intent to comply with the Claims Regulations provisions of ERISA. However, if the Plan fails to establish or follow reasonable claims procedures, as defined by ERISA, then a Covered Person shall be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedies under section 502(a) of ERISA.

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE FOR THE APPEAL OF A POST-SERVICE CLAIM: A Covered Person may elect to have another individual file an appeal of a Post-Service Claim on behalf of the Covered Person involving an Adverse Benefit Determination. To designate the individual or provider as an "authorized representative", the Covered Person must send a written statement to the Third Party Administrator, naming the individual or provider designated to act on behalf of the Covered Person for the review of the Adverse Benefit Determination (an assignment of benefits by a Covered Person does not constitute a designation of an authorized representative). All communications regarding the appeal will be directed to the authorized representative, unless the Covered Person includes a written request to receive copies, also.

EXAMINATION: The Plan Administrator shall have the right and opportunity to have the Covered Person examined whose Injury or Illness is the basis of a Post-Service claim hereunder when and as often as it may reasonably require during the time the claim is pending under the Plan. However, if a claim is pended for the results of the examination, the claim determination must be made under the time limits described above for processing a Post-Service Claim. If the examination is not conducted within the time limits described, then the claim will be denied, but can be appealed in accordance with the appeals procedure for Post-Service Claims. The Plan Administrator shall also have the right and opportunity to have an autopsy performed in a case of death where it is not forbidden by law.

PAYMENT OF CLAIMS: All Plan benefits are payable to the Employee, or subject to any written direction of the Employee. All or a portion of any indemnities provided by the Plan on account of hospital, nursing, medical or surgical services may, at the Employee's option and unless the Employee requests otherwise in writing not later than the time of filing proof of such loss, be paid directly to the hospital or person rendering such service; however, if any such benefit remains unpaid at the death of the Employee or if the Employee is a minor or is, in the opinion of the Plan Administrator, legally incapable of giving a valid receipt and discharge of any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Employee; wife, husband, mother, father, child, or children, brother or brothers, sister or sisters. Any payment so made will constitute a complete discharge of the Plan Administrator's obligation to the extent of such payment and the Plan Administrator will not be required to see the application of the money so paid.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed expenses. It applies when the Employee or any eligible dependent that is covered by 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 ("*Primary*") and the other plan pays a reduced benefit ("*Secondary*"). This Plan will always pay either 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.

Please see "Dependent Eligibility" under the section entitled "Eligibility, Effective Date and Termination Provisions" regarding further information on spouses of Employees on this Plan.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans.

As permitted by law, the Plan may, without your consent:

1. Obtain information from all plans involved.
2. Reimburse such other plans, if it is determined that benefits have been paid.
3. Release to other plans any information necessary to coordinate benefits.
4. Obtain reimbursement from any other plan when benefits have been paid from this plan that should have been paid by any other plan.
5. Obtain a refund of any amount, which exceeded 100% of allowable expenses.

BENEFITS SUBJECT TO THIS PROVISION: All benefits contained in the Plan Document are subject to this provision except drugs covered under the Prescription Drug Benefit and Weekly Income Benefits (if applicable).

COORDINATION PROCEDURES: Any plan which does not have a Coordination of Benefits or similar provision will pay its benefits first. If a plan does contain a Coordination of Benefits or similar provision, the rules establishing the order of benefit determination are:

The benefits of a plan, which covers the individual for whom, claim is made other than, as a Dependent will be determined before the benefits of a plan, which covers the individual as a dependent.

1. The benefits of a plan, which covers the individual for whom, claim is made, as a dependent will be determined by what is called the "birthday rule". Under this rule the plan which covers the parent whose birthday occurs earlier in the Calendar Year (month and day only) will be primary. If the parents have the same birthday, the plan that covered the parent longer will pay first and the other plan will pay second. However, if this Plan is coordinated with a plan that contains the gender-based rule and as a result the plans do not agree on the order of benefits, the gender-based rule will determine the order. However, if the dependent is a dependent child of divorced or separated parents, the order of payment will be as follows:
 - if the parent with custody has not remarried, his or her plan will be payable before the plan of the parent without custody.
 - if the parent with custody has remarried, his or her plan will be payable before the plan of the stepparent or the parent without custody; and the stepparent's plan will be payable before the plan of the parent without custody.
 - however, if there is a court decree which sets forth a financial duty for the child's health care expenses, the plan of the parent with such financial duty will be payable first.
2. If the above rules do not decide which plan's benefits are payable first, the plan which has covered the person for the longest time will be payable first except that a plan that covers a person other than as a COBRA beneficiary, laid-off Employee or retired Employee, or dependent of such person, will determine the benefits that will pay first. A plan that covers a person as a COBRA beneficiary, laid-off Employee or retired Employee, or dependent of such person, will determine its benefits second.
3. Benefits under Medicare after the first 30 months of End Stage Renal Disease will be payable before this Plan's benefits are payable. If a Covered Person has Medicare coverage for End Stage Renal Disease as of August 5,

1997, this Plan will be primary to Medicare for eligible charges incurred from the period of August 5, 1997 to the date that the Covered Person has had 30 months of Medicare coverage.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: For the purpose of determining the applicability of and implementing the terms of this provision of the Plan or any provision of similar purpose of any other plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information with respect to any person, which the company deems to be necessary for such purpose. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

SUBROGATION/RIGHT OF REIMBURSEMENT: As a condition to receiving benefits under this plan, Covered Person(s) receiving medical or Disability benefits agree to transfer to the Plan their rights to recover damages in full for such benefits when the Illness or Injury occurs through the act or omission of another person. If the Covered Person recovers any such medical or Disability expenses from the third party or his representative, whether by judgment, settlement or otherwise, related to the third party's acts or omissions, the Covered Person agrees to reimburse the Plan in full from the amounts recovered for any medical or Disability expenses paid by it. If a repayment agreement is required to be signed, all rights of recovery are transferred to the Plan regardless of whether it is actually signed. It is only necessary that the Injury occur through the act or omission of a third party. The Plan's rights of full recovery may be from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault or school insurance coverage which are paid or payable. The Plan's subrogation rights are full and complete and they exist even though the Covered Person does not receive full compensation or recovery for all costs, Injuries, damages, loss or destruction. The Plan may enforce its reimbursement rights by requiring the Employee to assert a claim to any of the foregoing coverage to which he may be entitled. The Plan will not pay fees or costs associated with a claim/lawsuit without express written authorization.

RIGHT OF RECOVERY: Whenever payments have been made by the Plan Administrator with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at this time, to satisfy the intent of this provision, the Plan Administrator shall have the right, exercisable alone and in its sole discretion, to recover such payments to the extent of such excess from among one or more of the following, as the Plan Administrator shall determine: any persons to or for, or with respect to whom such payments were made, and/or any insurance companies and any other organizations.

MEDICARE PROVISION: Active Employees age 65 and over, and dependent spouses age 65 and over, who have medical coverage under this Plan are entitled to Benefits on the same basis as active Employees and dependent spouses under age 65. This Plan will pay medical benefits primary to Medicare. If, however, the person elects Medicare coverage as the Primary payor of benefits, that person will be deemed to have waived all medical coverage under this Plan for himself and his dependents. Although such persons electing Medicare as the Primary payor of benefits will no longer be covered for medical benefits under this Plan, they may continue to be eligible for benefits other than medical benefits, if any, under this Plan (such as dental and/or vision benefits).

For companies with 100 or more active employees: if an Employee (other than a retiree) and/or covered dependent are under age 65, eligible for Medicare Disability, and have medical coverage under this Plan, this Plan will pay medical benefits primary to Medicare with the exception of benefits received from Medicare after the first 30 months of End Stage Renal Disease, in which case Medicare will pay primary to this Plan. (If a Covered Person has Medicare coverage for End Stage Renal Disease as of August 5, 1997, this Plan will be primary to Medicare for eligible charges incurred from the period of August 5, 1997 to the date that the Covered Person has had 30 months of Medicare coverage.)

For companies with less than 100 active employees: if an Employee and/or covered dependent are under age 65, eligible for Medicare Disability, and have medical coverage under this Plan, Medicare will pay primary to this Plan.

These provisions do not necessarily apply to COBRA beneficiaries. See Continuation of Coverage (COBRA).

PLAN INFORMATION

EFFECTIVE DATE: The effective date of the Plan (original effective date with AAG) is January 1, 2004.

WHO HAS RESPONSIBILITY FOR THE OPERATION AND ADMINISTRATION OF THE PLAN? The Named Fiduciary, Designated Legal Agent and Plan Administrator is Coshocton County Commissioners who has the authority to control and manage the operation and administration of the Plan. Although the Plan Administrator has hired a Third Party Administrator to manage the day-to-day operations of the Plan, the Plan Administrator has the sole authority to amend the Plan, to determine its policies, to appoint and remove third party administrators, and exercise general administrative authority over them. The Plan Administrator has the sole discretionary authority and responsibility to review and make final decisions on all claims to benefits according to the provisions of the Plan and, in the event that the item in question is not specifically addressed in the Plan, then the decision will be made by the Plan Administrator in accordance with its interpretation of the Plan.

BASIS ON WHICH PAYMENTS ARE TO BE MADE (CONTRIBUTIONS): The Employer pays for all costs related to the Plan solely out of its general assets, however, Employees are required to reimburse the Employer for a portion of those costs on the following basis.

Employee Medical and Prescription Drug Coverage:	Contributory
Dependent Medical and Prescription Drug Coverage:	Contributory

Employee Dental Coverage:	Contributory
Dependent Dental Coverage:	Contributory

The Plan Administrator shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed by each Covered Employee.

FUNDING POLICY: Notwithstanding any other provision of the Plan, the Employer's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions as set forth in the preceding paragraph entitled "Basis on Which Payments are to be Made". In the event that the Employer terminates the Plan, then as of the effective date of termination, the Employer (and Covered Persons) shall have no further obligation to make additional contributions. In addition, coverage for allowable claims filed after such Plan termination date shall be limited to any remaining Employer contributions not required to pay claims filed before the effective Plan termination date.

MEDICARE MODERNIZATION ACT: This plan is written with the intent to comply with the applicable provisions of the Medicare Modernization Act. The Plan must provide you with an annual notice regarding the Plan's prescription drug coverage; it must state whether the prescription drug coverage under this Plan is "creditable" or "non-creditable", as defined in the Medicare Modernization Act. The Plan must also provide this notice to you, upon your written request. If you are eligible for Medicare and you have questions regarding your prescription drug coverage under this Plan, please contact your Employer.

PLAN AMENDMENTS: This document contains all the terms of the Plan and may be amended from time to time by the authorized person or persons designated by the Plan Administrator.

The Plan Administrator shall notify all Covered Persons of any Plan modifications or changes that constitute a "material reduction in covered services or benefits" no later than 60 days of the date such changes or modifications become effective. Covered Persons will be notified of all other modifications or changes no later than 210 days after the close of the Plan Year in which the amendment making such changes or modifications has been adopted. Such notifications shall be in the form of a Summary of Material Modifications unless incorporated in an updated Summary Plan Description.

TERMINATION OF PLAN: Although the Plan is meant to continue on an indefinite basis, the Employer reserves the right at any time to unilaterally terminate the Plan by a written instrument to that effect. All previous contributions by the Employer shall continue to be issued for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination, or shall be used for the purpose of providing similar benefits to Covered Persons, until all contributions are exhausted.

If the Plan is terminated, the Plan Administrator will notify all Covered Persons as soon as it is administratively feasible but no later than the date of termination unless due to reasons beyond the Plan Administrator's control.

If the Plan is terminated and if, for whatever reason, there are insufficient monies to fund the cost of benefits incurred prior to the date of termination, the Covered Person will be responsible for the cost of such benefits (his claims) incurred prior to the date the Plan terminates.

TERMINATION BY DISSOLUTION, INSOLVENCY, BANKRUPTCY, MERGER, ETC.: This Plan shall automatically terminate if the Employer (1) is legally dissolved, (2) makes any general assignment for the benefit of its creditors, (3) files for liquidation under the Bankruptcy code, (4) merges or consolidates with any other entity and it is not the surviving entity, or if it sells or transfers substantially all of its assets, or goes out of business, unless the Company's successor in interest agrees to assume the liabilities under this Plan as to the Covered Persons.

PROTECTED HEALTH INFORMATION (PHI): Protected Health Information (PHI) is individually identifiable health information, including demographic information, which is collected, created or received by a health care provider, a health plan, an employer or a health care clearinghouse that relates to: your past, present or future physical or mental health or condition; the provision of health care to you or; the past, present, or future payment of claims for health care for you.

The Plan has been amended consistent with the applicable requirements of the § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, parts 160 through 164. Herein, it will be referred to as the "HIPAA Privacy Rule".

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule; the Plan designates the Plan Sponsor to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule, including entering into business associate contracts and accepting certification from the Plan Sponsor.

The Plan will disclose Protected Health Information (PHI) to the Plan Sponsor, or provide for or permit the disclosure of PHI to the Plan Sponsor by a health insurance issuer or HMO, but only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of the "HIPAA Privacy Rule", regarding the permitted and required uses and disclosure of Protected Health Information by the Plan Sponsor; the Plan Sponsor agrees to comply with the Plan provisions on PHI. The Plan must not disclose and must not permit the disclosure of PHI to the Plan Sponsor unless the certification has been signed.

Permitted Disclosure of Protected Health Information to the Plan Sponsor: Unless otherwise permitted by law and subject to obtaining the written certification discussed above, the Plan may disclose Protected Health Information (PHI) to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI for the permitted disclosures listed below:

1. The Plan (and any business associate acting on behalf of the Plan) will disclose PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out administrative functions on behalf of the Plan; such disclosure will be consistent with the provisions of the HIPAA Privacy Rule.
2. All disclosures of PHI by the Plan's business associate or health insurance issuer to the Plan Sponsor will comply with the HIPAA Privacy Rule.
3. The Plan (and any business associate acting on behalf of the Plan) may not disclose PHI to the Plan Sponsor for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
4. The Plan Sponsor will not use or further disclose PHI other than as described herein and permitted by the HIPAA Privacy Rule.
5. If the Plan (or the Plan's health insurance issuer) provides PHI to the Plan Sponsor, the Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides PHI, agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.

6. The Plan Sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
7. The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in the Plan Document (as amended) and in the HIPAA Privacy Rule, of which the Plan Sponsor becomes aware.

Disclosure of Protected Health Information by the Plan Sponsor: The Plan Sponsor agrees to the following conditions with respect to any Protected Health Information disclosed to it by the Plan; the Plan Sponsor will:

1. Make the PHI available to the Covered Person who is the subject of the PHI.
2. Make PHI available for amendment and incorporate any such amendments to the PHI in accordance with the HIPAA Privacy Rule.
3. Make and maintain an accounting of the disclosures of PHI, if the HIPAA Privacy Rule requires that it must account for such disclosures.
4. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.
5. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and will not retain copies when such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
6. Ensure that the required adequate separation between the Plan and Plan Sponsor is established and maintained.

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

The Plan may disclose summary health information to the Plan Sponsor, in accordance with the HIPAA Privacy Rule, if the Plan Sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from insurance companies or other health plans for providing health coverage under or on behalf of the Plan.
2. Modifying, amending or terminating the Plan.

Required Separation Between the Plan and the Plan Sponsor: In accordance with the HIPAA Privacy Rule, the following list of classes of employees, who are under the control of the Plan Sponsor, may be given access to PHI received from the Plan: **Administrator/Clerk.**

This list reflects the classes of employees or job titles of individuals who receive PHI relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of PHI in violation of, or noncompliance with, the HIPAA Privacy Rule.

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

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (EPHI): This Plan is meant to comply with the applicable requirements of 45 C.F.R §164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing Plan sponsor's obligations with respect to the security of Electronic Protected Health Information.

"Electronic Protected Health Information" (EPHI) has the meaning set forth in 45 C.F.R. §160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media. The Plan Sponsor is responsible for establishing and maintaining reasonable safeguards of Electronic Protected Health Information that is created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan.

The Plan sponsor shall:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation, as required by 45 C.F.R. §164.504(f)(2)(iii) of the HIPAA Privacy Rule, is supported by reasonable and appropriate security measures;
3. Ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
4. Agrees to report to the Plan, within a reasonable time after the Plan Sponsor becomes aware, of any successful Security Incident that results in the successful unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information. The Plan Sponsor shall report to the Plan any other unsuccessful Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

The term "Security Incidents" 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.

DEFINITIONS

THE FOLLOWING ARE DEFINITIONS OF TERMS THAT MAY BE USED IN THE WORDING OF THIS SUMMARY PLAN DESCRIPTION. THESE DEFINITIONS ARE NOT MEANT TO IMPLY COVERAGE UNDER ANY BENEFIT UNLESS SPECIFICALLY PROVIDED UNDER THE PLAN.

ADVERSE BENEFIT DETERMINATION: An Adverse Benefit Determination of a claim means any denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit for which a claim must be submitted. An Adverse Benefit Determination includes a failure to cover an item or service because the item or service is determined to be Experimental or not Medically Necessary or not appropriate.

ALCOHOL; DRUG ABUSE; OR PSYCHIATRIC TREATMENT FACILITY: "*Alcohol; Drug Abuse; or Psychiatric Treatment Facility*" means an institution which complies with licensing and other legal requirements in the jurisdiction where it is located; is engaged mainly in providing services for the treatment of alcoholism; drug abuse; or mental and nervous disorders in return for compensation; the services include room, board and 24-hour-a-day nursing services; the services are supervised by a Physician or by a registered nurse. If the services are not supervised by a Physician, the institution must have a Physician available on a prearranged basis; it maintains daily clinical records; and it must not be mainly a place of rest, a place for the aged, or a nursing or convalescent home.

AMBULANCE: "*Ambulance*" means a specially designed or equipped vehicle which is licensed for transferring the sick or injured. It must have customary patient care, safety, and life-saving equipment, and must employ trained personnel.

AMBULATORY SURGICAL CENTER: "*Ambulatory Surgical Center*" means an institution or facility, either free standing or as part of a Hospital with permanent facilities, equipment and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of Pregnancy, shall not be considered to be an ambulatory surgical center.

AMENDMENT: "*Amendment*" means a formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Administrator.

ANTERIOR TEETH: "*Anterior Teeth*" means the incisor and cuspid teeth. The teeth are located in front of the bicuspid (pre-molars).

APPLIANCE: "*Appliance*" means any dental device other than a dental prosthesis.

BIOLOGICALLY BASED MENTAL ILLNESS: A "*Biologically Based Mental Illness*" is defined as schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder.

CALENDAR YEAR: "*Calendar Year*" means a period of time beginning on January 1 and ending December 31 of the same given year.

CHILD BIRTHING CENTER: "*Child Birthing Center*" means an Out-Patient facility which meets all of these requirements: It complies with licensing and other legal requirements in the jurisdiction where it is located; it is engaged mainly in providing a comprehensive birth service program to pregnant persons who are considered normal low risk patients; it has organized facilities for birth services on its premises; the birth services are performed by a Physician specializing in obstetrics and gynecology or, at his direction, by a Nurse midwife; it has 24-hour-a-day registered nursing services; and it maintains daily clinical records.

CLAIM FOR BENEFITS: A "*Claim for Benefits*" is any request for a plan benefit or benefits, made by a Covered Person (or by an authorized representative of the Covered Person) that complies with the Plan's reasonable procedure for making benefit claims. A claim for group health benefits includes "Pre-Service" Care Claims and "Post-Service" Claims.

COLLEGE: See definition of University.

COMPLICATION OF PREGNANCY: "*Complication of Pregnancy*" means that part of a Pregnancy during which abnormal conditions or concurrent disease significantly affect the Pregnancy's usual medical management. A complication may exist during the Pregnancy; during the delivery; or after the delivery. But a complication of Pregnancy does not include an elective caesarean section.

CONGENITAL ANOMALY: A defective development, abnormality, or malformation of a part of the body which is determined by a Physician to have been present at the time of birth, including cleft lip and cleft palate. Abnormality in this context refers to a medical condition which is contrary to the body's usual size, location, condition, or system and which prevents normal bodily function.

COSMETIC PROCEDURE: "*Cosmetic Procedure*" means a procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function.

COVERED EMPLOYEE: "*Covered Employee*" means any Employee meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

COVERED PERSON: "*Covered Person*" means any Employee or dependent of an Employee meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

CREDITABLE COVERAGE: "*Creditable Coverage*" shall have that definition contained in ERISA Section 701(c). Under this provision, Creditable Coverage generally includes periods of coverage under an individual or group health plan (including Medicare, Medicaid, governmental and church plans) that are not followed by a significant break in coverage of sixty-three (63) days or more. Creditable Coverage does not include coverage for certain excepted benefits under ERISA Section 706(c), including but not limited to coverage for liability, dental, vision, specified disease and/or other supplemental-type benefits.

CUSTODIAL CARE: "*Custodial Care*" means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not Disabled, in the activities included, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

DENTAL DISEASE, DISORDER OR INJURY: "*Dental Disease, Disorder or Injury*" A condition, which is related to the teeth, gums or the supporting tissue and bone. Dental injury means accidental injury only and all dental injuries sustained at one time are considered one injury. Dental Accidental injury does not include damages to the teeth, appliances or prosthetic devices, which results from chewing or biting food or other substances.

DENTAL HYGIENIST: "*Dental Hygienist*" A person who has been trained in an accredited school; who is licensed by the state in which he is practicing the art of dental prophylaxis; and who is practicing under the direction and supervision of a dentist.

DENTAL PROSTHESIS: "*Dental Prosthesis*" means a restorative service which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of abutment crowns, inlays and onlays, bridge pontics, complete and immediate dentures, partial dentures and unilateral partials. It also includes all types of crowns, veneers, inlays, onlays, implants and posts and cores.

DENTIST: "*Dentist*" means A Dentist or Oral Surgeon practicing within the scope of his license.

DURABLE MEDICAL EQUIPMENT: "*Durable Medical Equipment*" means equipment which is able to withstand repeated use; and used to serve a medical purpose; and not generally useful to a person in the absence of Illness or Injury.

ELIGIBLE EXPENSES: The term "*Eligible Expenses*" means any Medically Necessary treatment, services, or supplies that are not specifically excluded from coverage elsewhere in this Plan.

EMERGENCY: "*Emergency*" means a sudden and unexpected condition requiring immediate medical attention to prevent death or serious harm to health. (Examples: heart attacks, suspected heart attacks, coma, loss of respiration, stroke, asthmatic attack, dehydration, high fevers, acute appendicitis, fractures, concussions, and broken bones.)

EMPLOYEE: The term "*Employee*" means a person directly employed Full-Time in the regular business of, and compensated for services by the Employer.

EMPLOYER: "*Employer*" means Coshocton County Commissioners.

ENDODONTICS: "*Endodontics*" means the prevention, diagnosis and treatment of disease and injuries that affect the tooth pulp.

ERISA: The term "*ERISA*" refers to the Employee Retirement Income Security Act of 1974 or any provision or section thereof which is herein specifically referred to, as such Act, provision or section as may be amended from time to time.

EXPERIMENTAL: "*Experimental*" means the use of any procedure, treatment, facility, equipment, drug, device or supply which is not approved or accepted as standard medical treatment of the condition being treated or any such item requiring American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, National Institute of Health, American Dental Association or American Osteopathic Association or other governmental approval, if it is not granted at the time services are rendered. In determining if any treatment, procedure, facility, equipment, drug device or supply is Experimental, the Plan Administrator may consider the view of the state or national medical communities and the views and practices of Medicare, Medicaid and other government financed programs. Although a Physician may have prescribed treatment, such treatment may still be considered Experimental within this definition.

FAMILY: The term "*Family*" means a Covered Employee and his eligible dependents.

FULL-TIME: The term "*Full-time*" means working a minimum of thirty (30) hours per week in the service of the Employer unless hired on a temporary or seasonal basis, as determined by the Employer.

HOME HEALTH CARE AGENCY: "*Home Health Care Agency*" means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.
2. It has policies established by a professional group associated with the agency or organization. This professional group must have at least one Physician and at least one registered nurse (R.N.) to govern the services provided and it must provide full-time supervision of such services by Physician or registered nurse.
3. It maintains a complete medical record on each individual.
4. It has a full-time administrator.

HOME HEALTH CARE PLAN: "*Home Health Care Plan*" means a program for continued care and treatment established and approved in writing by the Covered Person's attending Physician following termination of a Hospital confinement as a resident In-Patient or in lieu of a Hospital confinement, and is for the same or related condition for which he was hospitalized or would have been hospitalized. The attending Physician must certify that the proper treatment of the Illness or Injury would require confinement or continued confinement as a resident In-Patient in a Hospital in the absence of the services and supplies provided as part of the Home Health Care Plan.

HOSPICE BENEFIT PERIOD: "*Hospice Benefit Period*" means the specified amount of time during which the Covered Person undergoes treatment by a hospice. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminally ill and the Covered Person is accepted into a hospice program.

HOSPICE CARE: "*Hospice Care*" means a prearranged, written outline of the care that will be provided for Palliative Care and management of an individual's terminal Illness. In-Patient Hospice Care means treatment certified by the attending Physician that it is Medically Necessary to be received in a facility which may or may not be part of a Hospital and meets all of the following requirements: it complies with licensing and other legal requirements in the jurisdiction where it is located; it is mainly engaged in providing In-Patient Palliative Care for the terminally ill on a 24-hour basis under the supervision of a Physician or a registered nurse. If the care is not supervised by a Physician, the In-Patient hospice facility must have a Physician available on a prearranged basis; it provides pre-death and bereavement counseling; it maintains clinical records on all terminally ill individuals; it is not mainly a place for the aged or a nursing or a convalescent home; and is approved for payment of Medicare Hospice benefits.

HOSPICE TEAM: "*Hospice Team*" means a group of service providers who must include at least a Physician and a registered nurse (R.N.) but may also include a social worker, counselor, or psychologist.

HOSPITAL: "*Hospital*" means a Veterans Administration Hospital (when care or treatment is provided for non-service related Injury or Illness) or an institution which meets all of the following conditions:

1. it is licensed and operated in accordance with the laws of jurisdiction in which it is located which pertains to Hospitals; is engaged primarily in providing medical care and treatment to ill and injured persons on an In-Patient basis at the patient's expense; maintains on its premises all the facilities necessary to provide for diagnosis and medical and surgical treatment of an Illness or an Injury; and such treatment is provided by under the supervision of Physicians with continuous twenty-four (24) hour nursing services by registered nurses; and
2. it qualifies as a Hospital, an alcohol or drug abuse or psychiatric Hospital, or a tuberculosis Hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO);
3. it is a provider of services under Medicare; and
4. it is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics or a nursing home.

The provisions shown above under items #2 and #3 do not apply when a Covered Person is visiting, traveling or temporarily residing in a foreign country and must be hospitalized during such absence from the United States due to medical necessity. Charges for translation services are not covered under the Plan.

HOSPITAL MISCELLANEOUS EXPENSES: "*Hospital Miscellaneous Expenses*" means the actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for room and board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

ILLNESS: "*Illness*" means a bodily disorder, disease, physical sickness, mental and/or nervous disorder, alcohol and/or drug abuse. All such disorders existing simultaneously, which are due to the same or related causes, shall be considered one Illness.

INCURRED EXPENSES: The term "*Incurred Expenses*" means those services and supplies rendered to a Covered Person. Such expenses shall be considered to have occurred at the time or date the service or supply is actually provided.

INJURY: "*Injury*" means a condition caused by accidental means, which results in damage to the Covered Person's body from an external force. Any loss which is caused by or contributed to by hernia of any kind will be considered a loss under the definition of Illness, and not as a loss resulting from accidental Injury.

IN-PATIENT: "*In-Patient*" refers to the classification of a Covered Person when that Person is admitted to a Hospital, hospice, or convalescent facility for treatment, and charges are made for room and board to the Covered Person as a result of such treatment.

INTENSIVE CARE UNIT: "*Intensive Care Unit*" means a section, ward, or wing within the Hospital which is separated from other facilities and is operated exclusively for the purpose of providing professional medical treatment for critically ill patients; it has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; provides constant observation and treatment by registered nurses (RNs) or other highly-trained Hospital personnel.

LIFETIME: Wherever the word "*Lifetime*" appears in this Plan in reference to benefit maximums and limitations, it is understood to mean, "while covered under this Plan". Under no circumstances does "*Lifetime*" mean during the lifetime of the Covered Person.

MALE PRONOUN: Use of the male pronoun, whenever used, includes the female.

MEDICALLY NECESSARY: "*Medically Necessary*" means health care services, supplies or treatment for a covered illness or injury which, in the judgment of the attending Physician, is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

MEDICARE: The term "*Medicare*" means the programs established by Title I of Public Law 89-98 (79 Statutes 291) as amended entitled "Health Insurance for the Aged Act", and which includes Parts A and B and Title XVIII of the Social Security Act (as amended by Public Law 89-97, 79) as amended from time to time.

MENTAL AND/OR NERVOUS DISORDER: "*Mental and/or Nervous Disorder*" means a mental, nervous, or emotional disease or disorder as defined in the standard nomenclature of the American Psychiatric Association.

MINOR EMERGENCY MEDICAL CLINIC: "*Minor Emergency Medical Clinic*" means a freestanding 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 clinic is open. The clinics' facilities must include x-ray and laboratory equipment and a life support system.

For the purpose of this Plan, a clinic meeting these requirements will be considered to be a Minor Emergency Medical Clinic, by whatever actual name it may be called; however, a clinic located as an extension of, or in conjunction with, or in any way made part of a regular Hospital shall be excluded from the terms of this definition.

MORBID OBESITY: "*Morbid Obesity*" is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the Physician's standard weight table for a person of the same height, age and mobility as the Plan Member.

NETWORK PHARMACY: The term "*Network Pharmacy*" means an independent pharmacy or a pharmacy within a chain store, which holds a valid Participating Pharmacy Agreement with Caremark. Caremark will be the Network Pharmacy for mail order service as well..

NETWORK PROVIDER: The term "*Network Provider*" means a provider of health care services that holds a valid Provider Agreement with Quality Care Partners, Ohio Health Group and IHG.

NURSE: "*Nurse*" means a Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or a Licensed Practical Nurse (L.P.N.).

ORTHOTIC APPLIANCE: "*Orthotic Appliance*" means an external device intended to correct any defect in form or function of the human body.

OUT-PATIENT: "*Out-Patient*" refers to the classification of a Covered Person when that Covered Person receives medical care, treatment, services or supplies at a clinic, a Physician's office, or at a Hospital or other facility when not a registered bed patient.

OUT-PATIENT ALCOHOLISM AND/OR DRUG ABUSE FACILITY: "*Out-Patient Alcoholism or Drug Abuse Facility*" means an administratively distinct governmental, public, private or independent unit or part of such unit that provides Out-Patient alcohol or drug abuse treatment and rehabilitation services and which provides for a Physician who assumes the overall responsibility for coordinating the care of all patients.

OUT-PATIENT PSYCHIATRIC FACILITY: "*Out-Patient Psychiatric Facility*" is an administratively distinct governmental, public, private or independent unit or part of such unit that provides Out-Patient mental health services and which provides for a psychiatrist who assumes the overall responsibility for coordinating the care of all patients.

PALLIATIVE CARE: "*Palliative Care*" means a course of treatment directed toward lessening or controlling pain. It makes no attempt to cure the individual's illness.

PANORAMIC X-RAY: "*Panoramic Radiograph*" means an extraoral radiograph on which the maxilla and mandible are depicted on a single film.

PERIODONTICS: The term "*Periodontics*" means the examination, diagnosis and treatment of diseases affecting the supporting and surrounding tissues of the teeth, including the gingiva, cementum, periodontal membrane and alveolar or supporting bone.

PHYSICIAN: A "*Physician*" means a properly licensed individual who provides Covered Services. Physician shall include Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DMD), Doctor of Surgical Chiropody (DSC), Chiropractor (DC), Doctor of Podiatry (DPM), Psychologist (PhD), Psychiatrist (MD), Optometrist (OD), Ophthalmologist (MD) and any other licensed health care practitioner who law requires be recognized as a Physician and who is operating within the scope of his license. Physician also means a licensed health care practitioner, who is legally licensed or certified, and within the scope of that license or certificate, is permitted to perform the services for which Benefits are provided under this Plan.

PLAN: The term "*Plan*" means, without qualification, the Coshocton County Commissioners Employee Health & Welfare Plan, the provisions of which are set forth in the Plan Document (upon which this Summary Plan Description is based) which may be amended from time to time.

PLAN ADMINISTRATOR: The term "*Plan Administrator*" means the Employer, who 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.

PLAN SPONSOR: The Plan Sponsor is Coshocton County Commissioners. The Plan Sponsor has established the Plan to provide benefits as described herein for Participating Employers and eligible Employees and their eligible dependents.

PLAN YEAR: "*Plan Year*" means a period of time commencing with the effective date of this Plan or the Plan Anniversary, and terminating on the date of the next succeeding Plan Anniversary.

POSTERIOR TEETH: "*Posterior Teeth*" means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.

POST-SERVICE CLAIM: A "*Post-Service Claim*" is any claim for benefits after the services have been rendered or incurred.

PREGNANCY: "*Pregnancy*" means that physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

PRE-SERVICE CARE CLAIM: If the Plan requires pre-certification for hospitalization, then the pre-certification will be considered a Pre-Service Care Claim for benefits. A claim will be considered a "Pre-Service" Care Claim only if the Plan requires pre-certification for the service being rendered. Refer to the section entitled "Cost Containment" for information on Pre-Service Care Claims (Non-Urgent and Urgent).

PSYCHIATRIC CARE: "*Psychiatric Care*", also known as psychoanalytic care, means treatment for a Mental and/or Nervous Disorder, alcoholism or drug addiction.

PSYCHOLOGIST: "*Psychologist*" means an individual holding the degree of Ph.D. and acting within the scope of his license.

REASONABLE AND CUSTOMARY: The term "*Reasonable and Customary*" refers to the designation of a charge as being the usual charge made by a Physician or other provider of services, supplies, medications, or equipment that does not exceed the general level of charges made by other providers with similar training and experience rendering or furnishing such care or treatment within the same area.

The term "*area*" in this definition means a county or such other area as is necessary to obtain a representative cross section of such charge. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or expertise.

In no event will the "*Reasonable and Customary*" charge exceed the actual amount charged by a Network Provider when such provider is utilized by a person eligible for Network Benefits under the Plan.

ROOM AND BOARD: "Room and Board" refers to all charges by whatever name called, which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care by whatever name called.

ROOT PLANING: "Root Planing" is a procedure designed to remove microbial flora, bacterial toxins, calculus, and diseased cementum or dentin on the root surfaces and in the pocket.

SCALING: "Scaling" means removal of plaque, calculus and stain from teeth.

SEMI-PRIVATE: "Semi-Private" refers to a class of accommodations in a Hospital or Skilled Nursing Facility in which at least two patients' beds are available per room.

SKILLED NURSING FACILITY: "Skilled Nursing Facility" means a licensed institution, or distinct part of one, operated according to law and one, which meets all of the following conditions:

1. it provides In-Patient care for persons convalescing from Injury or Illness, professional nursing services rendered by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.) and physical restoration service to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities; and
2. its services are provided for compensation from its patients and under the full time supervision of a Physician or registered graduate nurse; and
3. it provides 24-hour-per-day nursing service by licensed Nurses, under the direction of a full-time registered graduate nurse; and
4. it maintains a complete original record on each patient; and
5. it has an effective organization review plan; and
6. it is not other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardation, custodial, or educational care, or care of mental disorders; and
7. it is approved and licensed by Medicare.

This term shall also apply to expenses incurred in an institution referring to itself as a Convalescent Nursing Facility, Extended Care Facility, Convalescent Nursing Home, or any other similar name.

SURGERY: "Surgery" means any cutting procedure or procedure which involves the insertion of an instrument into an internal organ (such as cystoscopy and colonoscopy) or "underwater shock wave treatment".

TERMINAL ILLNESS: "Terminal Illness" means a disease or sickness where the Covered Person is expected to live six (6) months or less. This must be certified by the attending Physician.

THIRD PARTY ADMINISTRATOR: "Third Party Administrator" shall mean the person or firm employed by the Plan Administrator who is responsible for the processing of claims and payment of benefits, administration, accounting, reports and other services contracted for by the Plan Administrator. The Third Party Administrator for this Plan is Aultra Administrative Group.

UNIVERSITY: The term "University" means an institution accredited in the current publication of accredited institutions of higher education.

GENERAL PROVISIONS

LEGAL PROCEEDINGS: 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.

TIME LIMITATION: If any time limitations of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of any action at law or in equity, is less than that permitted by any law to which it is subject, such limitation is hereby extended to agree with the minimum period permitted by such law.

PROVIDER ACTS OR OMISSIONS: The Plan Administrator and/or Third Party Administrator is not responsible for the quality of care you receive from any person or facility. The Plan does not give anyone any claim, right or cause of action against the Employer, Plan Administrator or Third Party Administrator based on what a provider of health care, or supplies, does or does not do. This applies whether such provider is a Network Provider or not.

FREE CHOICE OF PHYSICIANS: The Covered Person shall have free choice of any legally qualified Physician or surgeon and the physician-patient relationship shall be maintained. At any time, the Covered Person may choose a Network Provider or any other provider who is qualified as defined in the Plan. The benefits shown in the Schedule of Benefits for "Network", however, shall apply only to the services and supplies that are furnished directly by a Network Provider unless otherwise shown in the Schedule of Benefits.

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

CONFORMITY WITH 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.

STATEMENTS: In the absence of fraud, all statements made by a Covered Person will be deemed representative and not warranties. No such representation will void the Plan Benefits or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Person.

MISCELLANEOUS: Section titles are for convenience of reference only, and are not to be considered in interpreting the Plan. No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of this Plan.

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

RIGHTS OF PARTICIPANTS: As a Participant under this Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts and collective bargaining agreements (if applicable), and a copy of the latest annual report (Form 5500 Series), if applicable, filed with the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series), if applicable, and copies of the updated summary plan description. The Plan Administrator may make a reasonable charge for the copies. If the Plan Administrator is required to do so by law, to furnish each Participant with a copy of a summary financial report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage under the Plan for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Refer to the section entitled "Continuation of Coverage (COBRA)" for information on your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under the Plan, if you have Creditable Coverage from another plan. You should be provided a certification of Creditable Coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a Pre-Existing Condition exclusion for 18 months for late enrollees after your first day of coverage, or, if earlier, the first day of the Waiting Period under the Plan.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the persons responsible for the operation of the benefit Plan. The persons who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union (if applicable), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a benefit under this Plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report (if applicable) from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful in your lawsuit, the court may require the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.