PLAN DOCUMENT AND

SUMMARY PLAN DESCRIPTION

OF THE GROUP HEALTH CARE PLAN

FOR THE COMMUNITY COLLEGE INSURANCE COOPERATIVE EMPLOYEES OF

DANVILLE AREA COMMUNITY COLLEGE

HIGH DEDUCTIBLE HEALTH PLAN

EFFECTIVE: JANUARY 1, 2016

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THE VALUE OF YOUR HEALTH BENEFIT PLAN

This document is a description of the **Danville Area Community College Group Health Benefit Plan** (the Plan). No oral interpretations can change this Plan.

This Health Benefit Plan provides you and your family with important protection against financial hardship that often accompanies illness or injury. It has been carefully designed to provide excellent medical, dental, and vision benefits and offers financial incentives if you seek the most efficient quality health care services available. The College provides the Health Benefit Plan for you and your family.

Vision coverage is available through the Vision Service Plan. Please contact VSP at 800-877-7195 for benefit information.

Coverage under the Plan will take effect for you and your eligible Dependents when you and such Dependents satisfy the waiting period and all eligibility requirements of the Plan.

The College fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents, explaining:

- How you become eligible to participate,
- What benefits are available to you and your family, and
- How the Plan is administered.

We hope you'll take the time to review your benefit coverage from **Danville Area Community College** and share with your family ways to do your part to make the health care system work cost effectively and efficiently for you.

Please contact your Human Resources Office and/or Claims Administrator should you have any questions regarding your Plan.

SCHEDULE OF BENEFITS HDHP/HRA/HSA

DEDUCTIBLE/OUT-OF-POCKET/PENALTIES INDIVIDUAL COVERAGE		
SUMMARY OF SERVICES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Mandatory Hospital Pre-Admission And Pre-Surgical Review *Refer To The Section Entitled "Utilization Review Program"*		
Non-Compliance Penalty		
All Surgeries	$400	
Hospital Admissions	$400	
Lifetime Benefit Maximum	Unlimited	
Calendar Year Deductible		
Individual	$2,000	$4,000
Note: The Individual Deductible must be met before any benefits are payable.		
Network/Non-Network expenses will be applied separately toward the satisfaction of both the Network and Non-Network Deductible amounts.		
Out-of-Pocket Maximum – ***(Including Deductible & Medical & RX Coinsurance)***		
Individual	$4,000	$8,000
Note: The Out-of-Pocket Maximum includes Out-of-Pocket expenses for the Member only.		
Network/Non-Network expenses will be applied separately toward the satisfaction of both the Network and Non-Network Out-of-Pocket Maximums.		

DEDUCTIBLE/OUT-OF-POCKET/PENALTIES
FAMILY COVERAGE

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Mandatory Hospital Pre-Admission And Pre-Surgical Review *Refer To The Section Entitled "Utilization Review Program"*		
Non-Compliance Penalty		
All Surgeries	$400	
Hospital Admissions	$400	
Lifetime Benefit Maximum	Unlimited	
Calendar Year Deductible		
Individual	$4,000	$8,000
Family	$4,000	$8,000
Note: The Family Deductible Maximum includes covered expenses which are used to satisfy deductibles for all family members combined.		
Network/Non-Network expenses will be applied separately toward the satisfaction of both the Network and Non-Network Deductible amounts.		
Out-of-Pocket Maximum ***(Including Deductible & Medical & RX Coinsurance)***		
Individual	$6,550	$16,000
Family	$8,000	$16,000
Note: The Family Out-of-Pocket Maximum includes Out-of-Pocket expenses for all family members combined.		
Network/Non-Network expenses will be applied separately toward the satisfaction of both the Network and Non-Network Out-of-Pocket Maximums.		

SPECIAL COVERAGES

Refer to Specific Section for Details

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Second Surgical Opinion	90% Deductible Applies	70% Deductible Applies
Expanded Women's Preventive Care Services as required under the Patient Protection and Affordable Care Act (PPACA)	100% No Deductible	
Preventive Care Services as required under the Patient Protection and Affordable Care Act (PPACA) include the following:	100% No Deductible	
• ***Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;***		
• ***Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;***		
• ***Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents; and***		
• ***Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.***		
• **The complete list of recommendations and guidelines can be found at:** • **http://www.healthcare.gov//preventive-care-benefits/**		
Smoking Cessation Program (*including office visits and prescriptions*)	100% No Deductible	
Charges for the diagnosis and treatment of Autism Spectrum Disorder	Benefits are based on place/type of service	Benefits are based on place/type of service
Lab Pass (Quest Diagnostic)	100% Deductible Applies	

PHYSICIAN AND OFFICE SERVICES

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Office Visits	90% Deductible Applies	70% Deductible Applies
Emergency Illness/Accident Office Visit	90% Deductible Applies	70% Deductible Applies
Surgeon	90% Deductible Applies	70% Deductible Applies
Diagnostic X-Ray & Lab	90% Deductible Applies	70% Deductible Applies
Independent Lab, Radiologist & Pathologist	90% Deductible Applies	*70% Deductible Applies
	Services Performed by a Non-Network Provider Which The Patient Did Not Have The Option To Choose will be payable at the Network rate.	
Allergy Injections	90% Deductible Applies	70% Deductible Applies
Allergy Testing	90% Deductible Applies	70% Deductible Applies
Acupuncture***, for treatment of chronic pain***	90% Deductible Applies	70% Deductible Applies
Christian Science Practitioner	90% Deductible Applies	70% Deductible Applies
Nurse Practitioner	90% Deductible Applies	70% Deductible Applies
Dietician Services and Consultation	90% Deductible Applies	70% Deductible Applies
Chemotherapy	90% Deductible Applies	70% Deductible Applies
Physical, Occupational & Speech Therapy, ***includes physical therapy for Multiple Sclerosis***	90% Deductible Applies	70% Deductible Applies
Chiropractic Services	90% Deductible Applies	70% Deductible Applies
	Calendar Year Maximum – 15 Visits	
Podiatric Services – ***(No Coverage for Routine Foot Care)***	90% Deductible Applies	70% Deductible Applies
Orthotics	90% Deductible Applies	70% Deductible Applies
Infertility Services	90% Deductible Applies	70% Deductible Applies
Other Covered Services	90% Deductible Applies	70% Deductible Applies

OUTPATIENT HOSPITAL & AMBULATORY SURGICAL CENTER		
SUMMARY OF SERVICES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Facility	90% Deductible Applies	70% Deductible Applies
Urgent Care Facility	90% Deductible Applies	70% Deductible Applies
Emergency Room		
Emergency	90% Network Deductible Applies	
Non-Emergency	90% Deductible Applies	70% Deductible Applies
Diagnostic X-Ray & Lab	90% Deductible Applies	70% Deductible Applies
Pre-Admission Testing	90% Deductible Applies	70% Deductible Applies
Surgeon	90% Deductible Applies	70% Deductible Applies
Physical, Occupational & Speech Therapy ***(Includes Physical Therapy for Multiple Sclerosis)***	90% Deductible Applies	70% Deductible Applies
Chemotherapy & Radiation Therapy	90% Deductible Applies	70% Deductible Applies
Assistant Surgeon, Anesthesiologist, Pathologist, Radiologist & Consulting Physician	90% Deductible Applies ****Services Performed by a Non-Network Provider Which The Patient Did Not Have The Option To Choose will be payable at the Network rate.***	*70% Deductible Applies
Other Covered Services	90% Deductible Applies	70% Deductible Applies

INPATIENT HOSPITAL		
SUMMARY OF SERVICES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Facility	90% Deductible Applies	70% Deductible Applies
Room, Board & Miscellaneous	90% Deductible Applies	70% Deductible Applies
Nursery	90% Deductible Applies	70% Deductible Applies
	Baby & Mother's Charges Will Be Combined	
Surgeon	90% Deductible Applies	70% Deductible Applies
Physician Visits	90% Deductible Applies	70% Deductible Applies
Private Duty Nursing	90% Deductible Applies	70% Deductible Applies
Assistant Surgeon, Anesthesiologist, Radiologist, Pathologist & Consulting Physician	90% Deductible Applies	*70% Deductible Applies
	****Services Performed by a Non-Network Provider Which The Patient Did Not Have The Option To Choose will be payable at the Network rate.***	
Other Covered Services	90% Deductible Applies	70% Deductible Applies

OTHER COVERED SERVICES

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Extended Care Facility	90% Deductible Applies	70% Deductible Applies
Home Health Care	90% Deductible Applies	70% Deductible Applies
Home Infusion Therapy	90% Deductible Applies	70% Deductible Applies
Hospice Care	90% Deductible Applies	70% Deductible Applies
Bereavement Counseling	90% Deductible Applies	70% Deductible Applies
Ambulance*		
Emergency	90% Network Deductible Applies	
Non-Emergency	90% Deductible Applies	*70% Deductible Applies
Prescription Drugs	90% Deductible Applies	70% Deductible Applies
Generic FDA approved forms of Contraceptives for Women	100% No Deductible	
Durable Medical Equipment*	90% Deductible Applies	*70% Deductible Applies
	Limited to the lesser of the purchase price or the total anticipated rental charges	
Prosthetic Appliances*	90% Deductible Applies	*70% Deductible Applies
	Includes replacements which are medically necessary or required by pathological change or normal growth	
If there is no network availability, the network benefit will apply.		

PRESCRIPTION DRUG PLAN
Covered Under the Medical Plan

PURCHASED OUTSIDE OF THE RETAIL OR MAIL ORDER PRESCRIPTION PLANS	**70% Non-Network Deductible and OOP applies.**
COVERAGE INCLUDES	**COVERAGE EXCLUDES**
♦ Federal Legend Drugs	♦ Growth Hormone
♦ AIDS Medications	♦ Diagnostic Agents
♦ Insulin	♦ Rogaine
♦ Diabetic Supplies	♦ Devices
♦ Needles & Syringes	♦ Children's Vitamins
♦ Imitrex-vial & auto injector (48 kits per yr)	♦ Blood Products (RhoGAM)
♦ Dexedrine to age 25	♦ Anorexiants, Diet Drugs
♦ Prenatal Vitamins	♦ Life Style Drugs
♦ Retin-A to age 25	♦ OTC Counterparts
♦ Accutane to age 25	♦ Cosmetic Drugs
♦ Injectables	♦ Vitamins
♦ Bee Sting Kits	
♦ Genetically Engineered Drugs	
♦ Injectable Fertility, Fertility Drugs	
♦ Vaccinations/Immunizations	
♦ Smoking Cessation Products	
♦ FDA approved forms of Contraceptives for Women	

Expenses Related To Charges In Excess Of Benefit Maximums, Charges In Excess Of Reasonable And Customary Fees And Non-Compliance Penalties Do Not Accumulate Toward The Out-of-Pocket Maximum.

Any Maximums Which Are Stated In Dollar Amounts, Number Of Days Or Number Of Treatments And Which Limit Either The Maximum Benefits Payable Or The Maximum Allowable Covered Expense Are The Combined Maximums Under The Network and Non-Network Level Of Benefits.

DENTAL SCHEDULE OF BENEFITS

DENTAL SCHEDULE OF BENEFITS	
Plan Year Maximum Benefit	$1,200
Plan Year Deductible	
Individual	$50
Family	N/A
For Basic, Major & Orthodontic Services. The Deductible does not apply to Preventive Services.	
Co-Insurance Factor	
Preventive Services	100%
Basic Services	80%
Major Services	50%
Orthodontia*	
Deductible Co-Insurance	Part of Plan Year Deductible 100%
Lifetime Maximum	$1,200
Limited to Dependent Children under age 19	

PLAN PARTICIPATION

You must enroll for coverage under this Plan by obtaining an enrollment form from the Human Resources Office. Complete the form in full, sign and return it promptly to the Human Resources Office.

ELIGIBLE EMPLOYEES

All full-time employees who are regularly scheduled to work at least thirty (30) hours per week

WHEN EMPLOYEES BECOME ELIGIBLE

WAITING PERIOD

A "***Waiting Period"*** is the time between the first day of employment and the first day of coverage under the Plan.

ENROLLMENT DATE

The ***"Enrollment Date"*** is the first day of coverage or, if there is a waiting period, the first day of the waiting period.

You are eligible for coverage on the first day of full-time employment.

If you return from a leave of absence which qualifies under the Family and Medical Leave Act (FMLA) and you chose not to retain health coverage under this Plan during such leave, your coverage will be reinstated upon return from such leave, without any waiting period if you previously satisfied any applicable waiting period.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

Your coverage begins on the date on which you become eligible for Plan benefits provided you have completed an enrollment form and make any required contributions.

If you apply for coverage on or before your eligibility date, or within ten (10) days after your original enrollment date, your coverage will begin on your original eligibility date.

If you terminate your employment, for any reason, during your eligibility waiting period and are subsequently re-employed, you must complete the same eligibility waiting period as applied to a new employee. This requirement applies to both you and your eligible dependents.

REINSTATEMENT FOR COVERAGE

For an Employee who is terminated and rehired within 13 weeks, coverage will be effective immediately, so long as all other eligibility criteria are satisfied; or

For an Employee who has break in service of at least 4 weeks (and less than 13 weeks) and the preceding length of employment was less than the length of the break in service period, the new hire waiting period applies; or

For an Employee who is terminated and rehired in excess of 13 weeks, coverage will be effective upon satisfying the new hire waiting period and all other eligibility criteria

ENROLLMENT PERIODS

There are four (4) instances when members may change their benefit selections:

1. Annual Benefit Choice Period
2. Change in Family Status
3. Special Enrollment Events
4. Other Qualified Special Circumstances

Annual Benefit Choice Period

During The Annual Benefit Choice Period, you my initiate action to change your coverage. All health changes initiated during the Annual Benefit Choice Period, are effective on January 1st.

Covered Persons may make the following changes during the Annual Benefit Choice Period:

1. Change health plans.
2. Add or drop dependent coverage.

As required under the Internal Revenue Code, coverage elected during the Annual Benefit Choice Period remains in effect throughout the entire year, unless the Covered Person experiences:

1. A qualified change in family status, or
2. A special enrollment event, or
3. A qualified special circumstance.

Change in Family Status

As defined by the Internal Revenue Service, Covered Person's experiencing a change in family status has the ability to change health coverage. When a

Covered Person experiences a change in family status, the Covered Person has sixty (60) days from the date the change in family status occurs to submit a written request to the College Office requesting changes in their coverage.

A change in family status has occurred when the Covered Person experiences such events as:

1. Divorce;

2. Dissolution of a Civil Union;

3. Death of a spouse or dependent;

4. Change in Covered Person's or spouse's employment status (i.e., part-time to full-time or vice versa, or entering or returning from non-pay status);

5. Spouse's employer makes significant changes in premium costs (30% or greater change) or coverage;

6. Spouse is provided group insurance through employer for the first time;

7. Reinstatement of coverage that terminated due to non-payment of premium;

8. Dependent no longer meets eligibility criteria;

9. Dependent becomes eligible;

10. Court order results in the Covered Person gaining or losing custody of a dependent;

11. Court decree establishes a member's financial responsibility for a child's medical, dental, or other health care;

12. Change in Public Aid recipient status or Medicare status; or

13. Coordination of spouse's annual election period – must have written statement from spouse's plan indicating this is the only time dependent coverage may be changed.

Special Enrollment Events

A Covered Person has the ability to change health coverage when the following Special Enrollment events occur:

1. Marriage;
2. Civil Union;
3. Birth;
4. Adoption or placement for adoption;
5. Spouse loses employment;
6. Spouse's employer discontinues all coverage; or
7. Dependent becomes ineligible for other coverage.

When a change in family status, special enrollment event or special circumstance occurs, you have sixty (60) days from the event to submit a written request to the College Office requesting change in your coverage.

Effective Dates

Coverage changes are effective the later of:

1. The date the request for change was signed; or
2. The date the event occurred.

Remember: Benefit Choice Changes are effective January 1 of each year.
Children's Health Insurance Program Reauthorization Act of 2009. An Employee (or Dependent) who is eligible, but not enrolled in this Plan, may enroll if:

a. The Employee or Dependent was covered under Medicaid or the Children's Health Insurance Program at the time coverage under this Plan was previously offered to the individual; and

   If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that coverage under Medicaid or the Children's Health Insurance Program was the reason for declining enrollment; and

The Employee or Dependent loses eligibility for Medicaid or the Children's Health Insurance Program; and

The Employee or Dependent requests enrollment in this Plan not later than sixty (60) days after the date Medicaid or the Children's Health Insurance Program coverage ends; or

b. The Employee or Dependent has declined enrollment for himself or Dependent and later becomes eligible for a premium assistance subsidy for group health coverage through Medicaid or the Children's Health Insurance Program; and

   The Employee or Dependent requests enrollment in this Plan not later than sixty (60) days after the date of eligibility determination for a premium assistance subsidy for group health coverage through Medicaid or the Children's Health Insurance Program.

Effective Date

Coverage will become effective not later than the first day of the first month beginning after the date the completed request for enrollment is received.

LATE ENROLLMENT

"Late Enrollee" means an individual who enrolls under the Plan other than during the first ten (10) day period in which the individual is eligible to enroll under the Plan or during the Annual Benefit Choice Period or because of a Qualifying Change in Status.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage as a Late Enrollee is not treated as a waiting period.

EMPLOYEES WHO ARE NOT ELIGIBLE

Temporary employees.

Part-time employees - those who are regularly scheduled to work less than thirty (30) hours per week

WHEN EMPLOYEES CEASE TO BE ELIGIBLE

All Plan coverage will terminate on the earliest of the following dates:

The end of the month following the date your employment terminates ***(example: employment terminates June 6, coverage terminates June 30th).***

The end of month following the date you cease to be in a class of employees eligible for coverage.

The end of month following the date you cease to be an eligible employee.

The end of the period for which you made any required contributions, if you fail to make any further required contributions.

The date the Plan is terminated.

The end of the month following the date you enter the armed forces of any country on a full-time active duty basis.

If you are absent from work due to an approved leave of absence, other than a Family and Medical Leave Act leave, coverage terminates at the end of the month in which termination of employment with Danville Area Community College occurs.

If you are absent from work due to a disability, coverage terminates at the end of the month following no more than one year from the date of the disability, not to run concurrent with Family and Medical Leave Act (FMLA).

This Plan intends to comply with the provisions of the Family and Medical Leave Act (FMLA) effective August 5, 1993.

Refer to the section entitled COBRA for information regarding continued coverage after you cease to be eligible under the Plan.

FAMILY MEDICAL LEAVE ACT (FMLA)

If a Covered Employee ceases active service due to a Company approved Family Medical Leave of absence in accordance with the requirements of Public Law 103-3 (or in accordance with any state or local law which provides a more generous medical or family leave and requires continuation of coverage during leave), coverage will be continued under the same terms and conditions which would have been provided had the Covered Employee continued active service.

If the Covered Employee does not return to active service after the approved Family Medical Leave or if the Covered Employee has given the employer notice of intent not to return to active service during the leave, or if the Covered Employee has exhausted the week FMLA leave entitlement period, coverage may be continued under the Continuation of Coverage (COBRA) provision of this Plan, provided the Covered Employee elects to continue under the COBRA provision. Continuation of Coverage (COBRA) will be provided only if the following conditions have been met:

1. the Covered Employee or Covered Dependent was covered under this Plan on the day before the FMLA leave began or becomes covered during the FMLA leave; and

2. the Covered Employee does not return to active service after an approved FMLA leave; and

3. without COBRA, the Covered Employee or Covered Dependent would lose coverage under this Plan.

However, these conditions do not entitle a Covered Employee to COBRA if the Company eliminates, on or before the last day of the Covered Employee's FMLA leave, coverage under this Plan for the class of Employees (while continuing to employ that class of Employees) to which the Covered Employee would have belonged if the Covered Employee had not taken FMLA leave.

Continuation of Coverage (COBRA) will become effective on the last day of the FMLA leave as determined below:

1. the date a Covered Employee fails to return to active service after an approved family medical leave;

2. the date the Covered Employee informs the Company of intent not to return to active service; or

3. the date a Covered Employee exhausts the FMLA leave entitlement period and does not return to active service.

The Covered Employee will be totally responsible for the contributions during the COBRA continuation if elected. Coverage continued during a family or medical leave will not be counted toward the maximum COBRA continuation period.

If a Covered Employee declines coverage during the FMLA leave period or if the Covered Employee elects to continue coverage during the family or medical leave and fails to pay the required contributions, the Covered Employee is still eligible under the Continuation of Coverage (COBRA) provision at the end of the FMLA leave. COBRA continuation will become effective on the last day of the FMLA leave.

The Covered Employee will be totally responsible for the contributions during the COBRA continuation if elected, however, the covered employee is not required to pay any unpaid contributions for the time coverage had lapsed during the leave.

If a Covered Employee voluntarily terminates coverage under this Plan during the FMLA leave or if coverage under this Plan was terminated during an approved family medical leave due to non-payment of required contributions by the employee and the employee returns to active service immediately upon completion of that leave, coverage will be reinstated as if the employee remained in active service during the leave, including dependent coverage, without having to satisfy any waiting period, limitations or evidence of good health provisions of this Plan, provided the employee makes any necessary contribution and enrolls for coverage within thirty-one (31) days of the return to active service.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that employers must meet for certain employees who are involved in the uniformed services (defined below). In addition to the rights that you have under COBRA, you (the Employee) are entitled under USERRA to continue the coverage that you (and your covered Dependents, if any) had under the Medical and/or Dental Plan.

You Have Rights Under Both COBRA and USERRA

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

Definitions

"Uniformed Services" means the Armed Forces, The Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

"Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster-response personnel of the National Disaster Medical System.

Duration of USERAA Coverage

General Rule: Twenty-four (24) month maximum. When a Covered Employee takes a leave for service in the uniformed services, USERRA coverage for the Employee (and covered dependents for whom coverage is

elected) begins the day after the Employee (and covered dependents) lose coverage under the Plan, and it can continue for up to twenty-four (24) months. However, USERRA coverage will end earlier if one of the following events takes place:

1. A premium payment is not made within the required time;
2. You fail to return to work within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
3. You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Returning to Work: Your right to continue coverage under USERRA will end if you do not notify the Company of your intent to return to work within the time required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed services was for less than thirty-one [31] days) or applying for reemployment (if your uniformed services was for more than thirty [30] days). The time for returning to work depends on the period of uniformed services, as follows:

Period of Service	Return-to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible.
More than 30 days but less than 181 days	Within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your won, the first day on which it is possible to do so.
More than 180 days	Within 90 days after completion of your service.
Any period if for purposes of an examination for fitness to perform uniformed service	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or

Period of Service	Return-to Work Requirement
	impossible through no fault of your own, as soon as is possible.
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Same as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years, but the two-year period may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods.

COBRA and USERRA coverage are concurrent. This means that COBRA coverage and USERRA coverage begin at the same time. However, COBRA coverage can continue for up to eighteen (18) months (it may continue for a longer period and is subject to early termination, as described in the COBRA section. In contrast, USERRA coverage can continue for up to twenty-four (24) months, as described above.

Premium Payments for USERRA Continuation Coverage

If you elect to continue your health coverage (or your spouse or your dependent children's coverage) pursuant to USERRA, you will be required to pay one hundred two percent (102%) of the full premium for the coverage elected (the same rate as COBRA). However, if your uniformed service period is less than thirty-one (31) days, you are not required to pay more than the amount that you pay as an active employee for that coverage.

Questions

If you have any questions regarding this information or your rights to coverage, you should contact your Human Resources Office.

Reinstatement of Coverage

When coverage under this Plan is reinstated, all provisions and limitations of this Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous under this Plan. The eligibility waiting period will be waived as if you had been continuously covered under this Plan from your original effective date. (This waiver of limitations does not provide coverage for any illness or injury caused by or aggravated by your military service, as determined by the VA. For complete information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act, contact your employer).

ELIGIBLE DEPENDENTS

Your legal spouse---See definition of "Spouse".

Your Civil Union Partner---See definition of “Civil Union Partner”.

If both partners in a Civil Union are covered employees and the partner carrying dependent coverage terminates coverage under the Plan, dependent coverage can be transferred to the partner who remains covered by the Plan provided the employee continues to be an eligible employee. If both partners are covered employees and one terminates coverage with the Plan, he or she may be covered as a dependent under the remaining partner's coverage.

Your Dependent Children under age twenty-six (26). --- See definition of “Child”.

A child who is under age eighteen (18) when he is placed with you for adoption and for whom you have assumed and retained a legal obligation for total or partial support in anticipation of adoption of such child.

A child you must cover due to a Qualified Medical Child Support Order (QMCSO) subject to the conditions and limits of the law.

Your unmarried Disabled Children over age twenty-six (26) if such Children were Disabled prior to attaining age twenty-six (26). You must provide satisfactory proof of each Child's incapacity and Dependency within thirty-one (31) days after the Child’s twenty-sixth (26th) birthday. Continuing proof of disability and Dependency will be required periodically.

Anyone who is eligible for coverage as an employee will not be eligible for coverage as both an employee and as a dependent.

Dependent children may not be covered by more than one employee.

If both a husband and a wife are covered employees and the spouse carrying dependent coverage terminates coverage under the Plan, dependent coverage can be transferred to the spouse who remains covered by the Plan provided the employee continues to be an eligible employee and the request is made within ten (10) calendar days of termination. If both a husband and wife are covered employees and one terminates coverage with the Plan, he or she may be covered as a dependent under the remaining spouse's coverage provided the request is made within ten (10) calendar days of termination.

Extended Dependent Age Coverage

Additional categories for dependent coverage have been added to the Plan due to the enactment of Illinois Public Act 95-0958.

Unmarried dependent Children under the age of twenty-six (26) who are not enrolled as a full-time student are eligible, residency requirements with the Employee or in Illinois are not required.

Unmarried military veteran dependent Children under the age of thirty (30) who are not enrolled as a full-time student are eligible, residency requirement with the Employee is not required but the dependent must be a resident of Illinois.

In addition military veteran dependent Children must have:

- Served in the active or reserve components of the U.S. Armed Forces, including the National Guard;
- Received a release or discharge other than a dishonorable discharge; and
- Submitted proof of service using a DD2-14 (Member 4 or 6) form, otherwise known as a “Certificate of Release or Discharge from Active Duty”.

There will be an initial one time ninety (90) day Enrollment Period beginning on the first day of the renewal month during which a dependent may enroll, this Plan’s renewal month is January. The effective date for dependents added within the ninety (90) day Enrollment Period will be consistent with the enrollment terms of the Plan. During the initial ninety (90) day enrollment

period, requirements for creditable coverage, continuous coverage or breaks in coverage will not be applied.

After the initial Enrollment Period Plans will allow enrollment for these eligible dependents during the Plan's annual enrollment period. For Plans that do not have an annual enrollment period, enrollment will be allowed during the thirty (30) day period immediately prior to the Plan's renewal date. To be added during this time, eligible dependents may need to meet a requirement of ninety (90) days of continuous coverage without a break in coverage of more than 63 days.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

If a Qualified Medical Child Support Order is issued for a Plan Participant's child, that child will be eligible for coverage as required by the order and the Plan Participant will not be considered a Late Entrant for Dependent coverage.

A description of the QMCSO procedures is available from the Plan Administrator upon request, free of charge.

DEPENDENTS EFFECTIVE DATE OF COVERAGE

You must enroll your Dependents for coverage under this Plan by completing an enrollment form and authorizing any required contributions.

Dependent coverage begins on the date on which you become eligible for Plan benefits.

If you apply for Dependent coverage on or before your eligibility date, or within ten (10) days after your original eligibility date, coverage for your Dependents will begin on your original eligibility date. However a new dependent being added as a full-time student does not become eligible for coverage until the first day of the month in which classes begin or the date coverage is requested, whichever is later

WHEN DEPENDENTS CEASE TO BE ELIGIBLE

All Plan coverage will terminate on the earliest of the following dates:

In the case of all your Dependents,
the date your coverage terminates or the Dependent ceases to be a Dependent as defined in this Plan.

In the case of your Spouse,
when you are legally separated or divorced.

In the case of your Civil Union Partner,
when your Civil Union is legally dissolved.

In the case of a Dependent Child,
at the end of the month after attaining age twenty-six (26).

In the case of a Disabled Child,
the end of the month in which the Dependent is no longer disabled or dependent upon you for support.

The date the Dependent Coverage is discontinued under the Plan.

The date the Dependent becomes covered as an employee.

The date the Dependent enters the armed forces of any country on a full-time active duty basis.

The end of the period for which you made any required contributions, if you fail to make any further required contributions.

Refer to the section entitled COBRA for information regarding continued coverage after a Dependent ceases to be eligible under the Plan.\

PREFERRED PROVIDER ORGANIZATION (PPO)

Certain hospitals and physicians may participate in a PPO Network. PPO providers have entered into an agreement to provide services at a discounted fee arrangement. The PPO offers access to quality health care services by conveniently located providers at substantial savings to the Covered Persons. Each Covered Person is responsible for verifying a provider's network membership status prior to each and any service to ensure the claim is covered at the higher benefit level. If your current providers are not participating in the PPO Network, ask your providers to contact the Network for an application for participation or, you can nominate the provider on the Network's website or call their provider referral department. The PPO Network can only provide the names, addresses, and phone numbers of participating providers; they cannot pre-certify a procedure or verify eligibility or benefits. A list of the hospitals and physicians participating in the PPO is also available through the internet or by calling the provider network that is listed on the ID card.

A Covered Person has freedom of choice in selecting a health care provider; however, there are benefit differences depending on whether services are rendered by a Network provider or by a Non-Network provider. These differences are shown on the Schedule of Benefits.

If a Covered Person is located in an area where Network providers are not available within a twenty-five (25) mile range, Network benefits will apply to Non-Network providers.

If a covered service or item is not offered through the PPO Network, benefits for covered expenses will be provided at the Network level of benefits. Examples of these types of services or items include, but are not limited to, ambulance, private duty nursing, durable medical equipment, extended care facility, etc.

If a Covered Person requires treatment for an accident or medical emergency, as defined, benefits for the initial treatment by a Non-Network provider will be paid as shown on the Schedule of Benefits.

Additionally, if a Covered Person is admitted to a Non-Network hospital as a result of a medical emergency, benefits for stabilization and initiation of treatment will be paid at the Network benefit level until it is medically appropriate for the Covered Person to be transferred to a Network hospital.

The determination of when the transfer is medically appropriate will be made by the Covered Person's physician.

If the Covered Person chooses to remain in a Non-Network hospital after it has been determined that he could have been transferred to a Network hospital, covered expenses will be paid at the Non-Network benefit level.

If charges are incurred for services performed by a Non-Network provider which the patient did not have the option to choose, which relate to:

- **A Network Confinement;**
- **A Network Out-Patient Procedure; or**
- **A Network Physician/Office Visit,**

(i.e., Assistant Surgeon, Anesthesia, Independent Lab, Pathology & X-Ray, etc.) benefits will be paid as shown on the Schedule of Benefits.

Should you choose a provider that is participating in the PPO network, that provider will discount fees charged for the services rendered. Such discounts will be identified on your Explanation of Benefits (EOB). The discounts offered by the participating providers will be credited to your billing record. Should you ever be billed by a PPO provider for the discounts, notify the Claims Administrator who will then contact the provider for the appropriate adjustment.

IMPORTANT

The requirements of the Utilization Review program described below must be followed in order to receive full benefits under the Plan, whether a Network or Non-Network provider is used. In addition, when using a Network provider, benefits must be assigned to that provider.

UTILIZATION REVIEW PROGRAM

The benefits provided by this Plan are limited to charges for any non-emergency, elective surgery or hospital confinement only if the surgery or hospital confinement, or the length of hospital confinement, is necessary for the care and treatment of an illness or injury.

This Plan has implemented a program of Utilization Review so that you understand the medical necessity of a proposed Hospital confinement or surgery recommended by your Physician. The Utilization Review Service is staffed by medical professionals who consult with you and your Physician to determine the type of care required, the appropriate setting for such care, and quality, yet cost effective care for your condition.

PLEASE REFER TO YOUR HEALTH BENEFIT I.D. CARD FOR THE TELEPHONE NUMBER OF THE UTILIZATION REVIEW SERVICE.

ALL BENEFITS PROVIDED BY THIS PLAN FOR CHARGES FOR HOSPITAL CONFINEMENTS OR ELECTIVE SURGERY ARE SUBJECT TO THE FOLLOWING REQUIREMENTS:

PRE-ADMISSION REVIEW

For Non-Emergency Hospital Admissions:

A pre-admission authorization is required at least twenty-four (24) hours prior to admission to a hospital as a bed patient. You, a member of your family, your physician or the hospital must call the Utilization Review Service whenever a hospital admission is recommended.

The Utilization Review Service will evaluate your planned treatment based upon the diagnosis provided by your physician and established standards for medical care. After consultation with your physician the Utilization Review Service will provide written authorization to you, the hospital, and the Claims Administrator.

The Utilization Review Service's authorization does not verify eligibility or benefits. Questions regarding eligibility or benefits must be directed to the Claims Administrator.

For Emergency Hospital Admissions:

"Emergency Hospital Admission" means an admission for hospital confinement which, if delayed, would result in disability or death.

In case of an emergency hospital admission, you, your physician, the hospital or a member of your immediate family must inform the Utilization Review Service of the admission, by telephone, within forty-eight (48) hours after such admission.

For Maternity Hospital Admissions:

Maternity admissions are not considered emergencies. A pre-admission authorization is required at least two (2) months prior to the estimated date of delivery. You, a member of your family or your Physician must call the Utilization Review Service.

Although the Plan ***does*** require you to notify the Utilization Review Service of your pregnancy in advance of an admission, the first 48 hours following a vaginal delivery, or 96 hours following a cesarean section are automatically authorized. Stays in excess of the 48 or 96 hours will require authorization through the Utilization Review Service. Under Federal law, Group Health Plans may not restrict benefits for any hospital length of stay in connection with childbirth for the mother (if a Covered Person) or newborn child (if a Covered Person) 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, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

The Utilization Review Service must be informed of:

- The name and birth date of the patient
- The name and social security number of the employee
- The date of hospital admission or surgery
- The name of the employer
- The admitting diagnosis
- The name of the hospital
- The name and telephone number of the attending physician

CONTINUED STAY REVIEW

Before your scheduled discharge the Utilization Review Service will call the hospital and your physician to confirm your discharge. If additional days of confinement are required because of complications or other medical reasons, the Utilization Review Service will again evaluate the treatment and diagnosis in consultation with your physician. This process will continue until you are discharged from the hospital.

If hospital charges are incurred by a Covered Person for a period of hospital confinement which has NOT been authorized under the Continued Stay Review provisions, the eligible hospital charges for such confinement will be limited to the charges incurred during the period of hospital confinement initially authorized.

IF UTILIZATION REVIEW IS NOT USED

If hospital charges are incurred by a Covered Person for a period of hospital confinement and such confinement has NOT been authorized by the Utilization Review Service as set out under the Pre-Admission Review provisions, the penalty, as shown on the Schedule of Benefits, will apply.

THE NON-COMPLIANCE PENALTIES WILL NOT ACCUMULATE TOWARD THE REQUIRED DEDUCTIBLE(S) OR TO THE OUT-OF-POCKET MAXIMUMS.

RETROSPECTIVE REVIEW

The Utilization Review Service will review and evaluate the medical records and other pertinent data of an individual whose hospital stay, or a portion of his stay, was not authorized under the Pre-Admission and/or Continued Stay Review provisions of the Plan.

Requests for such review must be made, in writing, by the attending physician or hospital and must define the medical basis for the review.

Benefits will be limited to only those expenses incurred during the period of hospitalization which **would have been** authorized. Benefits are not payable for expenses related to any period of hospital confinement which is deemed not medically necessary.

PRE-SURGICAL REVIEW

Non-Emergency Surgery:

If your physician recommends non-emergency surgery, meaning ***any*** surgery that can be postponed without causing undue risk to the patient, you, a member of your family or your physician must contact the Utilization Review Service at least twenty-four (24) hours prior to the proposed surgery for pre-authorization.

Pre-Surgical Review is not required for minor surgical and diagnostic procedures performed in a physician's office.

VOLUNTARY SECOND SURGICAL OPINION BENEFIT

If your physician recommends non-emergency surgery, meaning surgery that can be postponed without causing undue risk, the Plan will pay for any necessary physician, x-ray or laboratory expense incurred for a second surgical opinion (and a third opinion, if the second opinion does not agree with the first opinion), if:

- The physician providing the second or third opinion is not associated with the physician who first recommended surgery.
- The physician providing the second or third opinion does not perform the surgery.
- The second or third opinion is obtained before the recommended surgery.
- The physician providing the second or third opinion is a Board Certified specialist in the appropriate specialty.
- The physician places the second or third opinion in writing.

An opinion confirming the advisability of surgery may provide greater peace of mind, and a non-confirming opinion may provide an alternative non-surgical method of treatment for the medical condition. If the patient does not use the Benefit, he will be passing up the chance to get additional medical advice at no cost.

The Second Surgical Opinion Benefit DOES NOT apply to expenses incurred for or in connection with:

- Surgical procedures which are not covered under the Plan;
- Minor surgical procedures that are routinely performed in a physician's office, such as incision and drainage of an abscess or excision of benign lesions;
- An opinion obtained more than three (3) months after a surgeon first recommended the elective surgical procedure.

DISEASE MANAGEMENT

Disease Management is a ***voluntary*** program that is designed to improve the lives of individuals suffering from chronic, yet treatable, diseases through education, lifestyle choices, self-care and healthcare intervention.

Chronic illness, such as heart disease, asthma and diabetes, are among the most prevalent, costly and treatable of all health problems. This ***free*** benefit program provides you with the opportunity to receive the tools and information you need to manage your healthcare and the related healthcare costs. The Disease Management program is staffed by medical professionals who will consult with you and your physician when a chronic medical condition is identified.

The goal of the Disease Management program is to intervene prior to a catastrophic medical event and to assist you in navigating through the healthcare system if a serious medical event does occur. To accomplish this goal, the Disease Management program provides the highest level of service at the earliest opportunity through education, intensive healthcare management and cost effective care for your specific condition.

The Disease Management program complies with HIPAA’s privacy regulations; your health information will be kept ***confidential*** and will only be shared with the people you choose.

The Process

Care Managers identify individuals with chronic medical conditions.

You will receive a telephone call from a Care Manager. If you cannot be reached by telephone, the Care Manager will send information regarding the Disease Management program to you in the mail.

You will complete a Health Risk Assessment (HRA) during a telephone interview with the Care Manager.

Following the Health Risk Assessment (HRA) process, the Care Manager uses disease-specific protocols and guidelines to educate you and manage your case. These guidelines outline the specific needs of your condition and the expected outcomes.

The Key Features and Benefits

You will receive a packet explaining the Disease Management program and educational information that is specific to your medical condition.

Care Managers will provide intensive planning and case management for medical situations by recommending alternate treatment plans, arranging home health care services and equipment rental and coordinating the services of the many providers that may be involved in these designated situations.

The Disease Management program does not verify eligibility or benefits. Questions regarding eligibility or benefits must be directed to the Claims Administrator.

CASE MANAGEMENT SERVICES

Case Management is an added service which is used to assist seriously ill or injured Covered Persons requiring long term care. Case Management nurses can provide intensive planning and management for these special situations by recommending alternate treatment plans, arranging home health care services and equipment rental and coordinating the services of the many providers that may be involved in these designated situations.

Examples of illnesses or injuries which may benefit from Case Management services are stroke, premature birth, some forms of cancer, severe burns and head injury.

The Covered Person must cooperate with the Case Manager and provide all relevant medical information regarding his condition; however, the choice of the course of treatment is the patient's.

Certain circumstances may cause the Plan Administrator to allow charges that would not otherwise be covered if the proposed alternative is shown to be cost effective. Prior to any final determination, the severity of the condition and the prognosis are taken into consideration. The Plan Administrator shall have the right to waive the normal provisions of the Plan when it is reasonable to expect a cost effective result without sacrifice to the quality of patient care.

MEDICAL EXPENSE BENEFIT

To receive benefits under the Medical Expense Benefit, you must satisfy the Deductible amount, if applicable, shown on the Schedule of Benefits. Once you have satisfied the Deductible, benefits are payable as shown on the Schedule of Benefits.

THE DEDUCTIBLE AMOUNT

The Individual Deductible amount is shown on the Schedule of Benefits and is the total amount of Covered Medical Expenses that you or your dependents must satisfy in a Calendar Year before you or your dependents are eligible to receive the Medical Expense Benefit.

Network/Non-Network Expenses will be applied separately toward the satisfaction of both the Network and Non-Network Deductible amounts.

FAMILY DEDUCTIBLE

When Covered Family Members have satisfied the Family Deductible amount as shown on the Schedule of Benefits in a Calendar Year (no person can contribute more than the Individual Deductible amount), the Plan will not apply Medical Expense Deductibles to the remaining Covered Medical Expenses for all Covered Family Members for that Calendar Year.

CO-INSURANCE FACTOR

After the Deductible is satisfied, the Plan will pay the applicable percentages of eligible Medical Expenses as shown on the Schedule of Benefits.

OUT-OF-POCKET MAXIMUM

If, in a Calendar Year, a Covered Person accumulates an Out-of-Pocket amount which equals the amount shown on the Schedule of Benefits, the Plan will pay 100% of any further Covered Medical Expenses incurred during the remainder of that Calendar Year.

Network/Non-Network expenses will be applied separately toward the satisfaction of both the Network and Non-Network Out-of-Pocket Maximums.

FAMILY OUT-OF-POCKET MAXIMUM

Embedded Out-Of-Pocket

When Covered Family Members have satisfied the Family Out-of-Pocket Maximum amount shown on the Schedule of Benefits in a Calendar Year (no person can contribute more than the Individual Out-of-Pocket amount), the Plan will not apply the Co-insurance Factor to and will pay 100%, from that date forward, of any further Covered Medical Expenses for all Covered Family Members for the remainder of that Calendar Year.

Expenses Related To Charges In Excess Of Benefit Maximums, Charges in Excess of Reasonable And Customary Fees, And Non-Compliance Penalties Do Not Accumulate Toward The Out-Of-Pocket Maximum.

Maximums Which Are Stated In Dollar Amounts, Number Of Days Or Number Of Treatments And Which Limit Either The Maximum Benefits Payable Or The Maximum Allowable Covered Expense Will Be Either The Maximum Under The Network or Non-Network Level Of Benefits.

COVERED MEDICAL EXPENSES

Reasonable and Customary charges incurred by, or on behalf of, a Covered Person for the following medically necessary items, if performed or prescribed by a physician for an injury or illness, subject to the Exclusions and Limitations of the Plan, are covered by the Medical Expense Benefit:

1. Hospital Room and Board including bed and board, general nursing care, meals and dietary services provided by the hospital. All semi-private or ward accommodations are covered.

   a. For private rooms, an allowance will be paid equal to the hospital’s semi-private room charge.

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

   c. If a private room is medically necessary for isolation purposes, the private room charge will be limited to the semi-private room charge.

   d. If Intensive Care, Coronary and Intermediate Care accommodations are medically necessary, the hospitals actual charges are covered.

2. Miscellaneous Hospital services and supplies including equipment and medications provided to registered inpatients.

3. Hospital charges for medically necessary outpatient services.

4. Services and supplies furnished by an ambulatory surgical center.

5. Residential Treatment Facility services.

6. Extended Care Facility services (refer to the specific section for coverage details).

7. Home Health Care services (refer to the specific section for coverage details).

8. Hospice Care services (refer to the specific section for coverage details).

9. Physician's services for surgery or other necessary medical care whether rendered in the office, hospital, home, extended care facility or hospice.

10. Charges for professional services of a nurse Practitioner under the supervision of a physician and billed by a physician, hospital, clinic or home health care agency.

11. Chiropractic care, by any name called, including all professional services for the detection and correction by manual or mechanical means (with or without the application of treatment modalities such as, but not limited to diathermy, ultrasound, heat and cold) of the spinal skeletal system and/or surrounding tissue to restore proper articulation of joints, alignment of bones or nerve functions. Such care may not be considered a covered expense if it is determined to be maintenance palliative.

12. Charges for acupuncture for the treatment of chronic pain. Services must be performed by a licensed physician trained in acupuncture, or a by a licensed acupuncturist.

13. Covered services rendered by a Christian Science Practitioner or Christian Science Nurse, only when the Christian Science Practitioner or Christian Science Nurse is working within the scope of their license.

14. Allergy testing and allergy injections.

15. Charges for dietician services and consultation ***but only*** when ordered in conjunction with a diagnosis of diabetes.

16. Licensed psychologist (PhD), licensed clinical social worker (LCSW), licensed clinical professional counselor (LCPC), licensed marriage and family therapist (LMFT), or licensed psychiatrist (MD) professional medical services for the outpatient treatment of psychiatric disorders and substance abuse only when acting within the scope of his license.

17. Chemotherapy or radiation therapy by x-ray, radium, radon or radioactive isotopes, or other such treatment or care recommended or prescribed by a Physician. ***Charges for infusion catheters to administer the drugs/agents are considered a surgical procedure and are paid separately.***

18. Medically necessary home infusion therapy under the supervision of a physician as an alternative to inpatient hospital care.

    Covered expenses include, but are not limited to:

    a. Instructional courses while confined in the hospital for the patient and a family member/designee;

    b. Medication and intravenous solutions; and

    c. Equipment rental and supplies such as infusion sets, syringes, and heparin.

19. Renal Dialysis treatment, including equipment, prescription drugs, supplies and the training of a person to assist the patient with home dialysis, when such services are provided in a Hospital, Dialysis Facility or in the home under the supervision of a Hospital or Dialysis Facility.

    Renal Dialysis benefits, notwithstanding any Plan provision to the contrary, the Plan shall reimburse treatment for, and related to, or in connection with End Stage Renal Disease (ESRD), chronic kidney disease, or other conditions requiring dialysis services and are subject to the following provisions:

    a. Subject to Pre-Certification, Cost Containment review, negotiation, and/or related administrative services as the designated by the Plan;

    b. The Plan provides for coverage of dialysis treatment at a cost no more than 125% of the Medicare allowable rate, for covered services and/or supplies, after deduction of all amounts payable by Coinsurance and Deductibles. (The Plan reserves the right to allow additional reimbursement levels based on a combination of condition severity, provider availability, geographic and market conditions.);

    c. For maximum coverage, enrollment in Medicare (Parts A and B) upon diagnosis of (ESRD) is recommended to avoid, to the extent possible under federal laws, additional uncovered expenses. If not enrolled, charges over 125% of the Medicare allowable rate, the Covered person may be subject to receiving a bill for the unreimbursed balance, which does not count towards the Deductible and Out-of-Pocket maximums under the Plan; and

d. All charges must be billed in accordance with generally accepted industry standards.

e. This provision shall supersede any provision in the Plan that may be in conflict.

20. Charges for physical and/or occupational therapy rendered by a licensed or registered physical or occupational therapist for the purposes of training to aid the restoration of normal physical functions lost due to an illness or injury. Therapy as part of an educational program and considered to be education and/or training and therapy when improvement is no longer documented are not covered.

21. Restorative or rehabilitative speech therapy by a qualified speech therapist when such therapy is administered:

    a. To a Covered Person whose previously-unimpaired speech is affected by an illness or injury; or

    b. To a Dependent Child as part of such Child's treatment for cerebral palsy or following surgery to correct a congenital anomaly of such Child.

22. Charges for reconstructive or cosmetic surgery provided the following conditions are met:

    a. The surgery must be required to correct a condition that results from an illness or injury; or

    b. The surgery is required to correct the congenital anomaly of a Dependent Child.

    Cosmetic surgery related to acne is not a covered expense.

23. Charges for the following expenses related to breast reconstruction in connection with a mastectomy in a manner determined in consultation with the attending physician and the patient:

    a. Reconstruction of the breast on which the mastectomy has been performed;

    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and physical complications in all stages of mastectomy, including lymphedemas.

24. Charges made by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or Christian Science Nurse for private duty nursing services when the attending physician certifies that such nursing care is medically necessary and the hospital staff cannot provide the service.

25. Anesthesia and its administration when rendered by a physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or an ambulatory surgical facility.

26. Medically necessary abortions.

27. Family planning services including family planning counseling, prescribing of contraceptive drugs, fitting of contraceptive devices and sterilization.

    Benefits are not available for repeating or reversing sterilization.

28. Covered services related to the diagnosis and/or treatment of infertility including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and injectable medication and infertility drugs. Infertility shall mean the inability to conceive a child after one (1) year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

    Benefits for in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures will be provided only when:

    a. The Covered Person has been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatment;

    b. The Covered Person has not undergone four (4) completed oocyte retrievals, except, if a live birth followed a completed oocyte retrieval, two (2) or more oocyte retrievals shall be covered. In no event will more than six (6) oocyte retrievals be covered by this Plan.

Benefits will not be provided for the following:

a. Services rendered to a surrogate mother for purposes of child birth;

b. Expenses associated with cryo-preservation and storage of sperm, eggs and embryos except for those procedures which use a cryo-preserved substance;

c. Medical or non-medical costs of anyone not covered under the Plan;

d. Travel costs;

e. Preimplantation genetic testing;

f. Persons who previously had a voluntary sterilization or person who are unable to achieve pregnancy after a reversal of a voluntary sterilization, and;

g. Infertility treatments deemed experimental in nature.

In addition, if in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures for the treatment of infertility are received, the procedures must be performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or the American Fertility Society minimal standards for programs of in-vitro fertilization.

29. Charges for obstetrical care are paid on the same basis as any other illness, including pre-natal care, pregnancy, and miscarriages. Benefits are provided for the pregnancy of a Dependent Child; however, benefits are not payable for the newborn unless and until the Employee (the grandparent) becomes the legal guardian for that child.

Group Health Plans may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother (if a Covered Person) or newborn child (if a Covered Person) 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, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal

law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

30. Charges incurred in connection with a Birthing Center (in lieu of hospital confinement) and medically necessary supplies furnished to the mother and necessary supplies furnished to the covered newborn child.

31. Routine newborn care while hospital confined, including Hospital nursery care and other Hospital services and supplies and physicians charges for pediatric care. ***This provision will apply even if the employee has single coverage. To be eligible for other covered services, or to be eligible for coverage for a sick newborn, the child must be added as a dependent.*** Covered medical expenses will be applied under the mother's coverage.

32. Circumcision when performed within the first thirty (30) days following birth. ***Charges for circumcision performed beyond the thirty (30) day time frame are considered to be covered expenses only when medical necessity is documented.***

33. Voluntary sterilizations, but not the reversal of such procedures.

34. ***Network Providers Only*** - Preventive Care Services as required under the Patient Protection and Affordable Care Act (PPACA). Refer to the Schedule of Benefits for additional information.

35. Blood and blood plasma in excess of the first three (3) pints in a calendar year.

36. X-ray and laboratory examinations, including allergy testing, for diagnostic or treatment purposes.

37. Professional ambulance service to and from a hospital or extended care facility where medical care and treatment necessary for the illness or injury can be provided, or

    a. Between hospitals and extended care facilities when a transfer is necessary to provide adequate care, or

    b. Regularly scheduled airline or railroad or air ambulance from the city in which the Covered Person became ill or was injured to and from the nearest hospital that provides treatment for such illness or injury. Only charges incurred for the first trip to and from a hospital shall be included.

38. Durable Medical Equipment limited to the lesser of the purchase price or the total anticipated rental charges. ***Coverage does not include repairs or replacements due to negligence or loss of the item, or expenses for newer, more efficient models.***

39. Charges for artificial limbs, eyes and other prosthetic devices to replace physical organs and body parts, including replacements or repairs which are medically necessary or required by pathological change or normal growth. Covered charges do not include expenses for the repair or replacement of damaged, lost or stolen devices or for items to be considered cosmetic in nature such as artificial fingernails, toenails, or eyelashes.

40. Medical and surgical supplies including bandages, surgical dressings, surgical stocking and ostomy supplies.

41. Casts, splints, crutches, cervical collars, head halters, traction apparatus and orthopedic braces.

42. Oxygen and rental of equipment for its administration.

43. The first pair of glasses or contact lenses, but not both, prescribed to treat glaucoma or keratoconus or resulting from cataract surgery.

44. Human Organ Transplants:

    Coverage includes benefits for medically necessary expenses related to human organ, bone marrow and tissue transplants. Expenses incurred by a live organ donor, who is without insurance coverage and is not covered under this Plan, will be covered. Expenses incurred for organs obtained through an organ bank or from a cadaver and expenses for storage and transportation that are reasonable and customary, are covered under this Plan. If both the recipient and the donor are covered under this Plan, the expenses will be treated separately.

45. Drugs and medications purchased through the Prescription Drug Plan and prescriptions purchased outside of the Prescription and Mail Order Plans will be covered as shown on the Schedule of Benefits.

46. Expenses for the following dental related services and supplies:

a. Treatment for the repair or alleviation of damage to sound natural teeth due to an accidental injury, other than from eating or chewing, or treatment of an injury to the jaw due to an injury.

b. Expenses billed by a hospital for inpatient and outpatient dental services will be covered if the Covered Person has a serious medical condition that requires hospitalization.

47. Emergency Medical Care and Emergency Accident Care:

    The initial outpatient treatment of a medical emergency or an accidental injury rendered in a hospital or by a physician. Treatment must be rendered within seventy-two (72) hours of an injury or illness.

    The term "Medical Emergency" means the sudden and unexpected onset of a medical condition manifesting itself by symptoms severe enough that the absence of medical attention could reasonably result in serious and permanent dysfunction of any bodily organ or part, or other serious and permanent medical consequences.

    Examples of medical emergencies include, but are not limited to, chest pain, suspected poisoning, severe and persistent abdominal pain, convulsions and emergencies by broadly accepted medical standards.

48. Charges for psychological testing.

49. Professional fees for the hearing exam associated with the care and treatment of an injury or illness. Hearing aids and associated costs, including the exam and evaluation of screening and obtaining a hearing aid are **not** covered.

50. Charges for Psychiatric and Substance Abuse care.

51. FDA approved medications used for conditions other than those for which they received FDA approval, when considered the standard of care and ***not*** part of a clinical study or in conjunction with any experimental treatment. For the purposes of this Plan, Standard of Care is defined as, charges for any care, treatment, services or supplies that are approved or accepted as essential to the treatment of any Illness or Injury by the American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, or the National Institute of Health, and recognized by the medical community as potentially safe and efficacious for the care and treatment of the Injury or Illness.

a. Charges for a shingles vaccine age sixty (60) and older.

b. Charges for a human papillomavirus vaccine (HPV).

c. Charges for the diagnosis and treatment of Autism Spectrum Disorder for children under age twenty-one (21). Autism Spectrum Disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

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

Treatment shall include the following care when prescribed, provided or ordered by a physician or a certified, registered or licensed health care professional with expertise in treating effects of Autism Spectrum Disorder when the care is determined to be Medically Necessary.

Psychiatric care;

Psychological care;

Habilitative or rehabilitative care including professional, counseling and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain and restore the functioning of an individual. Applied behavior analysis means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior; and

Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:

Self-care and feeding;
Pragmatic, receptive and expressive language;
Cognitive functioning;
Applied behavioral analysis, intervention and modification;
Motor planning; and
Sensory processing.

Upon request a provider of treatment for Autism Spectrum Disorders shall furnish medical records, clinical notes or other necessary data that substantiate that initial or continued medical treatment is medically necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

When making a determination of medical necessity for a treatment modality for Autism Spectrum Disorders, the Plan must make the determination in a manner that is consistent with the manner used to make that determination for other diseases or illnesses. Any challenge to medical necessity must be reviewed by a physician with expertise in the most current and effective treatment modalities for Autism Spectrum Disorders.

Coverage for Medically Necessary early intervention services must be provided by certified early intervention specialists.

Coverage is limited to a maximum benefit of $36,000 per person per Calendar Year.

52. Coverage for Habilitative Services for children less than nineteen (19) years of age with a congenital, genetic or early acquired disorder , including but not limited to autism or autism spectrum disorders and cerebral palsy. An early acquired disorder refers to a disorder resulting from early childhood illness, trauma, or injury or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking, or self-help skills. Habilitative Services included occupational therapy, physical therapy, speech therapy and other services prescribed by the treating physician in accordance with a treatment plan to enhance the ability of the child to function with a congenital, genetic, or early acquired disorder. Treatment must be Medically Necessary and not experimental or investigational.

Other exclusions and limitations of the Plan will apply including but not limited to coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, utilization review, Medical Necessity review, Case Management and other managed care provisions.

The required coverage does not include those services that are solely educational in nature or otherwise paid under State of Federal law for purely educational services.

Benefits will be provided the same as for any other illness.

53. Coverage for Medically Necessary preventive physical therapy for Covered Persons who have been diagnosed with Multiple Sclerosis. The therapy must be prescribed by a physician and include reasonably defined goals including sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy.

    Coverage will be subject to the same Deductible, Co-insurance, and cost sharing limitation, treatment limitation, Calendar Year Maximum or other limitation that is applied to physical therapy treatment for all conditions.

54. Charges for "Routine patient costs" incurred by a "qualified individual" in an "approved Clinical Trial" subject to the terms of this Plan.

    For purposes of this benefit the following definitions will apply:

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

    A "**qualified individual"** means a **covered person** who is eligible to participate in an "approved clinical trial" according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition and either the individual's doctor has concluded that participation is appropriate or the **covered person** provides medical and scientific information establishing that their participation is appropriate.

"Approved clinical trial" is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or a life threatening disease or condition likely to lead to death, unless the course of the disease or condition is interrupted. The "approved clinical trial" is federally funded or either conducted under an investigational new drug application reviewed by the Food and Drug Administration or a drug trial that is exempt from having an investigational new drug application.

EXTENDED CARE FACILITY

The Plan will provide benefits for charges made by an Extended Care Facility for convalescing from an illness or injury. Covered charges include:

- ♦ Room and board including charges for services such as general nursing care made in connection with room occupancy.
- ♦ Use of special treatment rooms, x-ray and laboratory examination, physical, occupational, or speech therapy and other medical services customarily provided by an Extended Care Facility except private duty or special nursing services or physician's services,
- ♦ Drugs, biological solutions, dressings, casts and other medically necessary supplies.

Benefits are provided when an individual is confined in an Extended Care Facility if:

- ♦ Care is certified at least seven (7) days prior to admission or at the time of transfer from an Acute Care Facility,
- ♦ The attending physician certified that twenty-four (24) hour nursing care is necessary for the recuperation from an injury or illness which required the hospital confinement, and
- ♦ He is confined in the Extended Care Facility to receive skilled nursing and physical restorative services for convalescence from the illness or injury that caused that hospital confinement.

HOME HEALTH CARE

The Plan will provide benefits for charges made by a licensed Home Health Care Agency for the following services and supplies furnished to a Covered Person in his home, or the place of residence used as such person's home for the duration of his illness or injury, for care in accordance with a Home Health Care Plan.

The care must be administered in lieu of a Hospital or Extended Care Facility confinement. Expenses for, but not limited to, the following are covered under this benefit:

- Part-time or intermittent nursing care by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.).
- Part-time or intermittent home health aide services.
- Physical, occupational, respiratory and speech therapy.
- Medical supplies, drugs and medicines prescribed by a physician, and x-ray and laboratory services.
- Medical social services.
- Nutritional counseling.
- Renal Dialysis

The following Home Health Care Expenses are not covered under the Plan:

- Meals, personal comfort items and housekeeping services.
- Services or supplies not prescribed in the Home Health Care Plan.
- Services of a person who ordinarily resides in your home, or who is a member of your or your spouse's family.
- Transportation services.
- Treatment of psychiatric conditions of any type, including substance abuse.

HOSPICE CARE

The Plan will provide benefits for care received through a home or inpatient Hospice Care program to which a terminally ill patient was referred by his attending physician. Expenses for, but not limited to, the following are covered under this benefit:

- Inpatient Hospice, limited to the semi-private room rate.
- Part-time or intermittent nursing care by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.).
- Physical, occupational, respiratory and speech therapy.
- Medical social services.
- Part-time or intermittent home health aide services.
- Medical supplies, drugs, and medicines prescribed by a physician, and x-ray and laboratory services.
- Physician's services.
- Dietary counseling.
- Bereavement counseling for immediate family members.

The following Hospice Care expenses are not covered under the Plan:

- Transportation services.
- Financial or legal counseling for estate planning or drafting a will.

PRESCRIPTION DRUG PROGRAM

The Plan provides benefits for eligible prescription drugs and medicines. Prescription drugs will be covered under the Medical Expense Benefit portion of the Plan, subject to the Deductible and Co-insurance factor, if not purchased through the authorized Prescription Drug Program.

SMOKING CESSATION PROGRAM

The Plan will provide benefits towards the cost of a Smoking Cessation Program for Covered Employees and Covered Dependents.

Services not eligible for this benefit include hypnosis and acupuncture.

For reimbursement under the Medical Expense Benefit Plan, submit your bill(s) indicating the patient's full name and the date of each purchase.

MEDICAL EXPENSE EXCLUSIONS AND LIMITATIONS

In addition to Exclusions and Limitations stated elsewhere in this Plan, the Medical Provisions of this Plan do not cover any loss caused by, incurred for or resulting from:

1. Hospitalization, services or supplies which are not medically necessary. Medically necessary hospitalization, services or supplies are those which are required for treatment of the illness or injury for which they are performed, which meet generally accepted standards of medical practice, and which are provided in the most cost-effective manner. Medically necessary hospital inpatient services are those which require inpatient care in an acute care hospital and cannot safely and effectively be provided in a physician's office, hospital outpatient department or other facility.

2. Charges for experimental drugs that:

   a. Are not commercially available for purchase;

   b. Are not approved by the Food and Drug Administration (FDA) for general use;

   c. Are not being used for the condition or illness for which they received FDA approval, except as shown as a covered expense;

   d. Are not recognized by state or national medical communities, Medicare, Medicaid or other governmental financed programs.

3. Charges for any care, treatment, services or supplies that are:

   a. Not approved or accepted as essential to the treatment of any illness or injury by any of the following: the American Medical Association, the U.S. Surgeon General, the U.S. Department of Public Health, or the National Institute of Health; or

   b. Not recognized by the medical community as potentially safe and efficacious for the care and treatment of the injury or illness.

4. Custodial care - 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 totally disabled, in the activities of daily living. Such activities include, 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.

5. Milieu therapy or any confinement in an institution primarily to change or control one's environment.

6. Services or supplies primarily for behavioral problems or social maladjustment or other anti-social actions which are not specifically the result of mental illness.

7. Reconstructive or cosmetic surgery, except for reconstructive surgery following a mastectomy or the correction of congenital deformities or conditions resulting from an illness or injury. Cosmetic surgery related to acne is not a covered expense.

8. Personal hygiene, comfort or convenience items that do not qualify as Durable Medical Equipment and are generally useful to the Covered Person's household, including but not limited to:

   a. All types of beds, other than hospital type beds that qualify as a Covered Expense;

   b. Air conditioners, humidifiers, air cleaners, filtration units and related apparatus;

   c. Whirlpools, saunas, swimming pools and related apparatus;

   d. Medical equipment generally used only by Physicians in their work;

   e. Vans and van lifts, stair lifts and similar other ambulatory apparatus;

   f. Exercise bicycles and other types of physical fitness equipment;

   g. Special toilet seats or grab bars.

9. Special braces, splints, equipment, appliances, battery or anatomically controlled implants unless medically necessary.

10. Expenses for physical therapy or occupational therapy considered to be maintenance in nature, in that medical documentation indicates that the maximum medical improvement has been achieved.

11. Speech therapy unless it is required because of a physical impairment caused by an illness, injury, or congenital deformity.

12. Recreational or educational therapy or forms of non-medical self-care or self-help training and any diagnostic testing.

13. Expenses incurred in obtaining an abortion, induced miscarriage or induced premature birth ***unless*** in the opinion of a physician such procedures are necessary for the preservation of the life of the woman seeking such treatment, ***or*** except in an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.

14. Charges for services provided by a Social Worker, except as shown as a covered expense.

15. Hospital charges that are incurred prior to the first Monday of a confinement that begins on a Friday, Saturday or Sunday, unless:

    a. Such confinement is due to a Medical Emergency; or

    b. Surgery is performed within twenty-four (24) hours after such confinement begins.

16. Charges for nutritional supplements, vitamins or minerals.

17. Charges for sterilization reversal.

18. Charges for any of the following items, including their prescription or fitting, except as shown as a covered expense:

    a. Hearing aids;

    b. Optical or visual aids, including contact lenses and eyeglasses;

    c. Wigs, toupees and hair transplants;

    d. Orthopedic shoes; and

    e. Any examination to determine the need for or the proper adjustments of any item listed above.

19. Charges for keratotomy or other refractive surgeries.

20. Charges for testing, training or rehabilitation for educational, developmental or vocational purposes.

21. Charges for marriage counseling and/or sexual therapy.

22. Services rendered by a health care provider specializing in the mental health care field who is a psychoanalytic candidate in training.

23. Charges for the diagnosis or treatment of obesity ***except*** when certified by a physician as morbid obesity (two times normal body weight).

24. Charges for treatment of a learning disability.

25. Routine foot care, including removal in whole or in part of corns, callosities (thickening of the skin due to friction, pressure or other irritation), hyperplasia (overgrowth of the skin), hypertrophy (growth of tissue under the skin) and the cutting, trimming or partial removal of toe nails, except for patients with the diagnosis of diabetes.

26. The care and treatment of the teeth, gums or alveolar process, and dentures, appliances or supplies used in such care and treatment, except as shown as covered expenses.

27. Services related to the diagnosis, treatment and/or appliance for temporomandibular joint (TMJ) disorders or syndromes (TMJ) myofunctional disorders or other orthodontic therapy.

28. Services for sex transformations or services for sexual dysfunctions which are not related to an organic disease including, but not limited to, surgery, implants or related hormone treatment.

29. Travel for health.

30. Charges for chelation (metallic ion) therapy.

31. Any item shown in General Exclusions and Limitations.

DENTAL EXPENSE BENEFIT

The Dental Expense Benefit has been designed to help you pay for your family's dental expenses and orthodontic treatment.

This benefit covers only those dental expenses which are performed by a licensed Dentist or by a licensed Dental Hygienist if rendered under the supervision and guidance of a Dentist.

Covered dental expenses are further limited to those services and supplies customarily employed for treatment of dental conditions only if rendered in accordance with accepted standards of dental practice.

If a dental service is performed that is not on the list and the service is not excluded by this Plan, but the list contains a similar service that is suitable for the condition being treated, then benefits will be payable as if the listed service was the one actually performed.

A charge will be considered to be incurred:

- For dentures or partials - on the date the impression is taken;
- For fixed bridgework, crowns, inlays or onlays - on the date the tooth or teeth are prepared and the final impressions are made;
- For root canal therapy - on the date the pulp chamber is opened and explored; and
- For all other services - on the date the service is performed.

DEDUCTIBLE AMOUNT

The Dental Deductible, if applicable, is the amount of Covered Dental Expenses which you must pay before benefits are payable by the Plan. The Dental Deductible is shown on the Schedule of Benefits and must be satisfied each Calendar Year.

Once you have satisfied the Deductible, benefits are payable on a Scheduled basis. The amounts listed on the schedule are the maximum benefits available under the Plan. You are responsible for any amount over the maximum benefit.

CALENDAR YEAR MAXIMUM BENEFIT

The Maximum Benefit shown on the Schedule of Benefits applies separately to you and to each of your Covered Dependents for dental services received in any one Calendar Year.

TREATMENT PLAN

If a course of treatment can reasonably be expected to involve Covered Dental Expenses of $600 or more, a description of the procedures to be performed and an estimate of the Dentist's charges should be filed with the Claims Administrator before beginning dental care.

Many Dentists require that you agree to the proposed treatment and charges before treatment begins. Therefore, it is valuable for you to know what the Dental benefit will pay before you make a financial commitment.

Have the Dentist complete the dental claim form including a written description of the proposed treatment, the estimated cost and x-rays. This process allows the Claims Administrator the opportunity to review Plan specifications such as deductibles, co-insurance percentages, benefit maximums, limitations and exclusions.

The Claims Administrator will notify the Dentist of the benefits payable. Consideration will be given to alternate procedures, services or courses of treatment that may be performed in order to accomplish the desired result.

If a Treatment Plan is not submitted in advance, the Claims Administrator reserves the right to make a determination of benefits payable considering alternate procedures, services, or courses of treatment, based on accepted standards of dental practice.

This Treatment Plan requirement will not apply to courses of treatment under $600 or to emergency treatment, routine oral examination x-rays, prophylaxis and fluoride treatments.

ORTHODONTIC EXPENSE BENEFIT

DEPENDENT CHILD COVERAGE ONLY

When your Covered Dependent Child incurs expenses on the accompanying "List of Covered Orthodontic Services" and such expense is incurred while this coverage is in force for your Dependent Child and treatment is rendered by a Dentist as defined herein, the Plan will pay the benefits as determined for the reasonable charges actually incurred.

ORTHODONTIC PROCEDURE

Orthodontic procedures means movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

ORTHODONTIC TREATMENT PLAN

The charges must be a part of an Orthodontic Treatment Plan which, prior to the performance of the procedures, has been (a) submitted to the Claims Administrator and (b) reviewed and returned to the Dentist showing estimated benefits. Submission of an Orthodontic Treatment Plan is not required if charges made or to be made total $600 or less. Such Treatment Plan must:

1. Provide a classification of the malocclusion,

2. Recommend and describe necessary treatment by orthodontic procedures,

3. Estimate the duration over which treatment will be completed,

4. Estimate the total charge for such treatment, and

5. Be accompanied by cephalometric x-rays, study models and such other supporting evidence as the Claims Administrator may reasonably require.

COVERED CHARGES

The total covered charges scheduled to be made in accordance with an Orthodontic Treatment Plan shall be payable in equal installments over a period of time equal to the estimated duration of the Orthodontic Treatment Plan and limited to the amounts shown on the Schedule of Benefits.

LIFETIME ORTHODONTIC MAXIMUM BENEFIT

The Maximum Benefit shown on the Schedule of Benefits applies separately to each of your covered dependents for all Orthodontic benefits received in a lifetime.

LIMITATION

Orthodontic procedures must commence prior to a Covered Dependent child attaining age nineteen (19) and the first active appliance must be installed while the child is covered under this Plan.

If these provisions are met, benefits for Orthodontic Services may continue beyond age nineteen (19) if the Dependent still meets the eligibility requirements.

COVERED SERVICES

PREVENTIVE SERVICES
Periodic Oral Examination
Limited Oral Evaluation (problem focused)
Comprehensive Oral Examination
Full Mouth X-Rays, Complete series, once in a period of 3 plan years
Periapical X-Rays
First Film
Each Additional Film
Bitewing X-Rays
Single Film
Two Films
Four Films
Panoramic Film, once in a period of 3 plan years
Prophylaxis, Adult, Twice each plan year
Prophylaxis, Child, Twice each plan year
Topical Application Fluoride, Child (**Including** Prophylaxis) Once each plan year, covered to age 19 only
Topical Application Fluoride, Child (**Excluding** Prophylaxis) Once each plan year, covered to age 19 only
Sealant, Pediatric, Per tooth, covered to age 19 only
Space Maintainers
Fixed Unilateral
Fixed Bilateral
Removable Unilateral
Removable Bilateral
Palliative emergency treatment of dental pain
BASIC SERVICES
Amalgam Fillings
Amalgam One Surface Primary
Amalgam Two Surface Primary
Amalgam Three Surface Primary
Amalgam Four Or More Surfaces Primary
Amalgam One Surface Permanent
Amalgam Two Surface Permanent
Amalgam Three Surface Permanent
Amalgam Four or more Surfaces Permanent **Resin Restorations**
One Surface Anterior
Two Surface Anterior
Three Surface Anterior
Four or more Surfaces involving Incisal Anterior Angle

Resin One Surface Posterior Primary
Resin Two Surface Posterior Primary
Resin Three or More Surface Posterior Primary
Resin One Surface Posterior Permanent
Resin Two Surface Posterior Permanent
Resin Three Surface Posterior Permanent
Other Restorative Services
Recement Inlay
Recement Crown
Crown-Prefabricated stainless steel primary
Crown-Prefabricated stainless steel permanent
Crown-Prefabricated Resin
Pulp Capping
Pulp-Cap – Direct excluding final restoration
Pulp-Cap – Indirect excluding final restoration
Pulpotomy – Therapeutic excluding final restoration
Root Canal Therapy (must include intra-operative radiographs)
Anterior excluding final restoration
Bicuspid excluding final restoration
Molar excluding final restoration
Retreatment by report:
Anterior
Bicuspid
Molar
Gingivectomy or Gingivoplasty
Per quadrant
Per tooth
Gingival Curettage
Per quadrant, by report
Gingival Flap Procedure
Including root planing, per quadrant
Mucogingival Surgery – Per quadrant
Osseous surgery, including flap and closure, per quadrant
Osseous Grafts including flap and closure
Single site
Multiple sites
Pedicle Soft Tissue Grafts
Single site
Free Soft Tissue Grafts
Single site
Provisional Splinting
Intracoronal, by report
Extracoronal, by report
Periodontal Scaling and Root Planing
Per quadrant
Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis

Periodontal Maintenance
Following active therapy
Unscheduled dressing change
Adjustments to Removable Prosthetics
Adjust complete maxillary denture
Adjust complete mandibular denture
Adjust partial maxillary denture
Adjust partial mandibular denture
Complete Denture Repair
Repair broken complete denture base
Replace missing or broken teeth on complete denture, each tooth
Partial Denture Repair
Repair acrylic saddle or base
Repair cast framework
Repair or replace broken clasp
Replace broken tooth, each tooth
Add tooth to existing partial denture
Add clasp to existing partial denture
Denture Rebase Procedure
Rebase complete maxillary denture
Rebase complete mandibular denture
Rebase partial maxillary denture
Rebase partial mandibular denture
Reline complete maxillary denture (chairside)
Reline complete mandibular denture (chairside)
Reline maxillary partial denture (charside)
Reline mandibular partial denture (chairside)
Reline complete maxillary denture (laboratory)
Reline complete mandibular denture (laboratory)
Reline maxillary partial denture (laboratory)
Reline mandibular partial denture (laboratory)
Other Fixed Prosthetic Services
Recement fixed partial denture
Fixed partial denture repair, by report
Extractions – includes local anesthesia, suturing if needed, and routine post-operative care
Single tooth
Each additional tooth
Surgical Extraction – includes local anesthesia, suturing if needed, and routine post-operative care
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flat and removal of bone and/or section of tooth
Removal of impacted tooth – soft tissue
Removal of impacted tooth – partially bony

Removal of impacted tooth – completely bony
Removal of impacted tooth – completely bony with unusual surgical complications
Surgical removal of residual tooth roots by cutting procedure
Additional Surgical Procedures
Biopsy or al tissue – hard
Biopsy of oral tissue – soft
Alveoloplasty in conjunction with extractions, per quadrant
Alveoloplasty not in conjunction with extractions, per quadrant
Frenulectomy (Frenectomy or frenotomy) separate procedure, by report
Occlusal guards, by report
Occlusal adjustment, limited
Occlusal adjustment, complete
General anesthesia – first 30 minutes
General anesthesia – each additional 15 minutes
MAJOR SERVICES
Crowns/Single Restorations
Crown-Resin Laboratory
Crown-Resin with high noble metal
Crown-Resin predominantly base metal
Crown-Resin with noble metal
Crown-Porcelain/Ceramic Substrate
Crown-Porcelain fused to high noble metal
Crown-Porcelain fused to predominantly base metal
Crown-Porcelain fused to noble metal
Crown-Full cast high noble metal
Crown-Full cast predominantly base metal
Crown-Full cast noble metal
Crown-3/4 cast metallic
Removable Prosthetics
Complete Denture – Maxillary
Complete Denture – Mandibular
Immediate Denture – Maxillary
Immediate Denture - Mandibular
Partial Denture Prosthetics (Removable)
Maxillary, resin base including conventional clasps, rests and teeth
Mandibular, resin base including conventional clasps, rests and teeth
Maxillary, cast metal base with resin saddles, including conventional clasps, rests and teeth
Mandibular, cast metal base with resin saddles, including conventional clasps, rests and teeth
Removable unilateral partial denture one piece, cast metal, includes clasps and teeth
Fixed Partial Denture Pontics (each abutment and each pontic constitute a unit in a bridge)
Pontic – Cast high noble metal

Pontic – Cast predominantly base metal
Pontic – Cast noble metal
Pontic – Porcelain fused to high noble metal
Pontic – Porcelain fused to predominantly base metal
Pontic – Porcelain fused to noble metal
Pontic – Resin with high noble metal
Pontic – Resin with predominantly base metal
Pontic – Resin with noble metal
Fix Partial Denture Retainer/Crowns
Crown – Resin with high noble metal
Crown – Resin with predominantly base metal
Crown – Resin with noble metal
Crown – Porcelain fused to high noble metal
Crown – Porcelain fused to predominantly base metals
Crown – Porcelain fused to noble metal
Crown – ¾ cast high metal
Crown – Full cast high noble metal
Crown – Full cast predominantly base metal
Crown – Full cast noble metal
ORTHODONTIC SERVICES
Orthodontic Services are Limited to the Lifetime Maximum Shown on the Schedule of Benefits
Limited Orthodontic Treatment Primary Dentition
Limited Orthodontic Treatment Transitional Dentition
Limited Orthodontic Treatment Adolescent Dentition
Interceptive Orthodontic Treatment Primary Dentition
Interceptive Orthodontic Treatment Adolescent Dentition
Comprehensive Orthodontic Treatment Transitional Dentition
Comprehensive Orthodontic Treatment Adolescent Dentition
Removable Appliance Therapy (patient can remove)
Fixed Appliance Therapy (patient cannot remove)

DENTAL EXPENSE EXCLUSIONS AND LIMITATIONS

The Dental Benefit provisions of this Plan do not cover any loss caused by, incurred for, or resulting from:

1. A service furnished a Covered Person for:

    a. Cosmetic purposes, unless necessitated as a result of accidental injuries sustained while such person was covered under this Plan and for the repair of which the service is furnished within one (1) year of the date of the accident and while the individual remains a Covered Person. For purposes of this limitation, facings on crowns or pontics posterior to the second bicuspid and the personalization and characterization of dentures shall always be considered cosmetic;

    b. Dental care to correct a congenital or developmental malformation, including but not limited to: cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and anodontia.

2. Orthodontia of deciduous (baby) teeth or adult orthodontia.

3. Replacement of lost, missing or stolen prosthetic device or any other device or appliance.

4. Replacement of lost, missing or stolen orthodontic appliances.

5. Appliances, restorations, or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, replacing tooth structure lost as a result of abrasion or attrition.

6. Dental services relating to the diagnosis or treatment including appliances for temporomandibular joint disturbances (TMJ) and myofunctional disorders, craniofacial pain disorders, and orthogantic surgery, however occlusal guards are covered.

7. A service not reasonably necessary or not customarily performed for the dental care of the Covered Person.

8. A service not furnished by a Dentist, unless the service is performed by a licensed Dental Hygienist under the supervision of a Dentist or an x-ray ordered by a Dentist.

9. Oral hygiene instruction, a plaque control program or dietary instructions.

10. Implantology, gold foil restorations or bleaching.

11. The initial placement of a partial or full removable denture or fixed bridgework, including crowns and inlays forming the abutments, if involving the replacement of five (5) or more natural teeth extracted prior to the Covered Person becoming covered under this Plan, unless the denture or fixed bridgework also includes the replacement of a natural tooth which is extracted while the Covered Person is covered under this Plan.

12. The replacement of a removable partial or denture or fixed bridgework by a new denture or new bridgework, or the addition of teeth to an existing partial removable denture to replace extracted natural teeth, is covered only due to one of the following:

    a. The replacement or addition of teeth is required to replace one or more natural teeth extracted while covered under this Plan.

    b. The existing denture or bridgework was installed at least five (5) years prior to its replacement and the existing denture or bridgework cannot be made serviceable or structural changes in the person's mouth require a new denture.

    c. An accidental bodily injury sustained while the Covered Person is covered under this Plan.

13. Any dental services or supplies which are included as covered expenses under any other provision in this Plan, or under any other group plan carried or sponsored by the College.

14. Services or supplies that do not meet accepted standards of dental practice including, but not limited to, services which are investigational or experimental in nature.

15. Services or supplies of the type normally intended for sport or home use such as athletic mouthguards, toothpaste, toothbrushes, etc.

16. Any item shown in General Exclusions or Limitations.

GENERAL EXCLUSIONS AND LIMITATIONS

This Plan does not cover and no benefits shall be paid for any loss caused by, incurred for or resulting from:

1. Charges in excess of Reasonable and Customary fees.

2. Services or supplies received from either an Employee's or Employee's spouse’s relative, any individual who ordinarily resides in the Employee's home or any such similar person.

3. Charges for failure to keep a scheduled visit or charges for completion of a claim form or for medical records.

4. Charges for telephone conversations, television rental or guest meals.

5. Services or supplies for which there is no legal obligation to pay or for which no charge would be made in the absence of this coverage.

6. Charges for or in connection with an illness or injury arising out of or in the course of any employment for wage, profit or gain.

7. Charges for or in connection with an illness or injury for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupation Disease Law or similar Local, State or Federal Statutes under which the Covered Person is entitled to benefits.

8. Charges for or in connection with an injury or illness arising out of or in the course of war, declared or undeclared, service in any military, naval, or air force of any country or international organization, or in any auxiliary or civilian noncombatant unit serving with such forces.

9. Services or supplies that are provided by the local, state or federal government and that part of the charges for any services or supplies for which payment is provided or available from the local, state or federal government (i.e., Medicare) whether or not that payment is received, except as otherwise provided by law.

10. Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are experimental or investigational in nature.

11. Charges for or in connection with an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a felony.

12. Services or supplies furnished by a hospital owned or operated by the United States Government or agency thereof, or furnished by a physician employed by the United States Government or agency thereof, to the extent permitted by law.

13. Charges incurred outside the United States if:

    a. The Covered Person traveled to such location to obtain medical services, drugs or supplies; or

    b. Such services, drugs or supplies are unavailable or illegal in the United States.

14. Charges for services required by any employer as a condition of employment, or rendered through a medical department, clinic or other similar facility provided by an employer or by a union employee benefit association or similar group of which the person is a member.

15. Health examinations required for the use of a third party ***except as shown as a covered expense.***

16. Treatment of any condition not caused by illness or not resulting from bodily injury, except as shown as a covered expense.

17. Expenses submitted more than one year from the ending date of the Calendar Year in which the charges was incurred, except that failure to submit within the stated time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to submit such claim in a timely manner and that the claim was submitted as soon as was reasonably possible.

18. Charges in excess of the benefits specified in this Plan.

OTHER HEALTH BENEFIT PLAN INFORMATION

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent payments of benefits which exceed expenses. It applies when the employee or any eligible dependent who 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 and the other plan(s) pay a reduced benefit. This Plan will always pay either its benefits in full or, when this Plan has secondary responsibility, a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of the total allowable expenses. Only the amount paid by this Plan will be charged against the Plan maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If requested, authorization must be given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayment. All benefits contained in this Plan are subject to this provision.

There is no coordination of benefits within this Plan. Coordination is applicable only with other plans.

DEFINITIONS

The term "Plan" as used herein will mean any plan providing benefits or services for, or by reason of, medical or dental treatment and such benefits or services are provided by:

- Group insurance or any other arrangement for coverage for Covered Persons in a group, whether on an insured or uninsured basis; or
- Group, blanket or franchise coverage; or
- Hospital or medical service organization on a group basis, group practice and other group prepayment plans; or
- A licensed Health Maintenance Organization (HMO); or
- Any coverage under Governmental programs, and any coverage required or provided by a statute; or

- Individual automobile insurance coverage based upon the principle of "No Fault" coverage; or

- Any coverage under a labor-management trusteed plan, union welfare plan, employer organization plan, employee benefit organization plan or such similar plan.

The term "Plan" does not mean individual or family plans or contracts, or any coverage for students which is sponsored by, or provided through a school or other educational institution.

The term "Plan" will be construed separately with respect to each policy, contract or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take the benefits or services of the other plans into consideration in determining benefits and that portion which does not.

The term "Allowable Expenses" means any necessary item or expense, the charge for which is reasonable, regular and customary, at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an allowable expense and benefit paid.

The term "Claim Determination Period" means a Calendar Year, or that portion of a Calendar Year during which the Covered Person for whom a claim is made has been covered under this Plan.

COORDINATION PROCEDURE

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits and all benefits payable under all other plans will not exceed the total Allowable Expenses incurred during any Claim Determination Period with respect to Covered Persons eligible for:

1. Benefits either as an insured person or employee or as a dependent under any other plan which has no provision similar in effect to this provision; or

2. Dependents' benefits under this Plan for a dependent who is also eligible for benefits as an insured person or employee under any other plan or as a dependent covered under another group plan; or

3. Benefits under this Plan for an Employee who is also eligible for benefits as an insured person or employee under any other plan, and has been covered continuously for a longer period of time under such other plan; or

4. If an eligible dependent elects membership in a Health Maintenance Organization (HMO) as an employee of another employer, benefits under this Plan are limited to co-insurance and/or deductibles not covered under the HMO and eligible expenses that are specifically excluded under the HMO. There will be no coverage under this Plan for any item not covered by the HMO because the dependent chose not to avail himself to the HMO participating provider.

ORDER OF BENEFIT DETERMINATION

In Coordination of Benefits, the Plan first decides which plan has primary responsibility for providing benefits. Primary responsibility is decided by these rules in the following order:

1. The Plan pays secondary to any and all PIP, Med-Pay or No-Fault coverage. The Plan has no duty of obligation to pay claims until PIP, Med-Pay or No-Fault coverage is exhausted;

   If you live in a state with no-fault auto insurance (PIP), your car insurance is the primary plan for medical expenses relating to an automobile accident. This Plan is secondary to PIP but only if you exceed the PIP maximum coverage limits. This Plan does not permit participants to opt out of no-fault auto insurance as the primary plan. If you should opt out, be aware that this Plan will reimburse you as the secondary plan only under the assumption that you have received primary reimbursement from your auto insurance to the maximum limit available. In other words, you will receive little or no reimbursement from this Plan . . . unless the accident expenses exceed the PIP maximum. Therefore, in order to be eligible for secondary reimbursement for automobile-accident related medical costs, a Plan participant: (1) must have maximum PIP coverage, and (2) must have exceeded that coverage limit;

2. The other plan has primary responsibility if it has no coordination of benefits provision;

3. Whichever plan provides benefits for the sick or injured person as a participant (employee), has primary responsibility before the plan covering the person as a dependent;

4. The plan that covers the person (and his dependents) as an active employee, pays before the plan that covers the person as a retired or laid-off employee or COBRA continuant.

5. If the claim is for a dependent child, the plan of the parent whose birthday falls earlier in a calendar year has primary responsibility, or if both parents have the same birthday, the plan covering the parent longer has primary responsibility. If the other plan does not have this rule but instead has a rule based on the gender of a parent, and, as a result the plans do not agree on the order of benefits, then the rule in the other plan will determine the order of benefits.

Dependent Child of Separated or Divorced Parents

1. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

   a. First, the plan of the parent with custody of the child;

   b. Then, the plan of the spouse of the parent with custody; and

   c. Finally, the plan of the parent without custody of the child.

2. However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, that plan is the primary plan. This paragraph does not apply with respect to any benefit period or calendar year during which any benefits are actually paid or provided before the entity has actual knowledge.

3. If the order of responsibility cannot be determined by the above rules, such as when the same individual is covered by two group plans, whichever plan has covered the ill or injured person for the longer period of time has primary responsibility.

The College has the right:

1. To obtain or share information with an insurance company or other organization regarding Coordination of Benefits without the Covered Person's consent; and

2. To require that the Covered Person provide the College with information on such other plans so that this provision may be implemented; and

3. To pay the amount due under this Plan to an insurer or other organization if this is necessary, in the College's opinion, to satisfy the terms of this provision.

WHEN ANOTHER PLAN HAS PRIMARY RESPONSIBILITY

When another plan has primary responsibility, it must first pay its full benefit. This Plan will then pay any remaining covered expenses up to the amount that it would have paid if it had primary responsibility, unless payment is excluded by a provision of the Plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

FACILITY OF PAYMENT

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

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in absence of this provision.

RIGHT OF RECOVERY

Whenever payments have been made by the Plan Administrator with respect to Allowable Expenses in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan Administrator shall have the right to recover such payments, to the extent of such excess, from any person or entity to, or for, or with respect to, whom such payments were made.

SUBROGATION

Subrogation/Right of Recovery

When the plan pays for expenses that were either the result of the alleged negligence of, or which arise out of any claim or cause of action which may accrue against, any third party responsible for injury or death to the Covered Employee or Dependent of the Covered Employee (hereinafter named the Covered Person) by reason of their eligibility for benefits under the Plan, the Plan has a right to equitable restitution and will advance benefits if the Covered Person agrees to the following.

The Covered Person will reimburse the Plan out of the Covered Person's recovery for all benefits paid by the Plan. The Plan will be reimbursed in full prior to the Covered Person receiving any monies recovered from any party or their insurer as a result of judgment, settlement or otherwise. The duty and obligation to reimburse the Plan also applies to any insurance. The Covered Person is obligated to repay the Plan even if the Covered Person is not fully compensated or made-whole from any money they receive. The Covered Person agrees to include the Plan's name as a co-payee on any settlement check. The Plan is paying benefits in reliance upon the Covered Person's agreement to the terms contained in this section.

The Plan has the right to the Covered Person's full cooperation in any case involving the alleged negligence of a third party. In such cases, the Covered person is obligated to provide the Plan with whatever information, assistance, and records the Plan may require to enforce the rights in this provision. The Covered Person further agrees that in the event that the Plan has reason to believe that the Plan may have a subrogation lien, the Plan will require the Covered Person to complete a subrogation questionnaire, sign an acknowledgment of the Plan's Subrogation rights and an agreement to provide ongoing information; before the Plan pays, or continues payments of claims according to its terms and conditions. Upon receipt of the requested materials, the Plan will commence, or continue, payments of claims according to its terms

and conditions provided that said payment of claims in no way prejudices the Plan's rights. If the Covered Person does not agree to the terms and conditions of the Plan's Subrogation Provision, related claims may be subject to disqualification, denial or loss of benefits.

The Plan may, but is not obligated to, take any legal action it sees fit against the third party or the Covered Person, to recover the benefits the Plan has paid. The Plan's exercise of this right will not affect the Covered Person's right to pursue other forms of recovery, unless the Covered Person and his legal representative consent otherwise.

In the event that the Claims Payer determines that a subrogation recovery exists, the Claims Payer retains the right to employ the services of an attorney to recover money due to the Plan. The Covered Person agrees to cooperate with the attorney who is pursuing the subrogation recovery. The compensation that the Plan's attorney receives will be paid directly from the dollars recovered for the Plan.

The Plan specifically rejects the "common fund" doctrine, whereas, it has no duty or obligation to pay a fee to the Covered Person's attorney for the attorney's services in making any recovery on behalf of the Covered Person.

The covered Person is obligated to inform their attorney of the subrogation lien and to make no distributions from any settlement or judgment which will in any way result in the Plan receiving less than the full amount of its lien without the written approval of the Plan.

The Covered Person further agrees that he will not release any third party or their insurer without prior written approval from the Plan, and will take no action which prejudices the Plan's subrogation right.

The Covered Person agrees to refrain from characterizing any settlement in any manner so as to avoid repayment of the Plan's lien or right to reimbursement.

The Plan Administrator retains discretionary authority to interpret this and all other plan provisions and the discretionary authority to determine the amount of the lien.

The Plan pays secondary to any and all PIP, Med-Pay or No-Fault coverage. The Plan has no duty of obligation to pay any claims until PIP, Med-Pay or No-Fault coverage is exhausted. In the event that the Plan pays claims that should have been paid by PIP, Med-Pay or No-Fault coverage under this

provision, then the Plan has a right of recovery from the PIP, Med-Pay or No-Fault carrier.

If you live in a state with no-fault auto insurance (PIP), your car insurance is the primary plan for medical expenses relating to an automobile accident. This Plan is secondary to PIP but only if you exceed the PIP maximum coverage limits. This Plan does not permit participants to opt out of no-fault auto insurance as the primary plan. If you should opt out, be aware that this Plan will reimburse you as the secondary plan only under the assumption that you have received primary reimbursement from your auto insurance to the maximum limit available. In other words, you will receive little or no reimbursement from this Plan . . . unless the accident expenses exceed the PIP maximum. Therefore, in order to be eligible for secondary reimbursement for automobile-accident related medical costs, a Plan participant: (1) must have maximum PIP coverage, and (2) must have exceeded that coverage limit.

Under the terms of the Plan, it is the absolute obligation of the Covered Person to reimburse the Plan if the Covered Person recovers from the other party or insurer, without the Plan’s knowledge, for the amount of benefits paid by the Plan for the Injury, Illness or Death.

Failure to reimburse the Plan shall permit the Plan to offset the amount due against the Covered Persons’ future claims submitted by covered members of his or her family. This Plan’s subrogation right is subject to ERISA, which preempts individual state law.

MEDICARE PROVISIONS

Medicare means Title XVIII (Health Insurance for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 or as later amended.

Full Medicare Coverage means coverage for all the benefits provided under Medicare including benefits provided under the voluntary program (Medicare Part B - doctor's portion) established by Medicare.

Medical Charges as used in this Provision with respect to any services, treatments or supplies, means the charges actually made for such services, treatments or supplies to the extent reasonable and customary.

ACTIVE EMPLOYEES AGE SIXTY-FIVE (65) OR OVER

For active employees age sixty-five (65) or over who continue to participate in this Plan, this Plan will provide its full regular benefits first and Medicare coverage would provide supplemental benefits for those expenses not paid by this Plan.

If the active employee's spouse is also enrolled in this Plan, this provision would apply to the spouse during the period of time the spouse is sixty-five (65) or over, regardless of the age of the employee.

This provision does not apply to individuals entitled to Medicare because of end stage renal disease (ESRD) and/or disability.

This provision intends to comply with the TEFRA Act of 1982, the DEFRA Act of 1985, the COBRA Act of 1985 and the OMBRA Act of 1986 and all similar Federal acts.

CERTAIN DISABLED INDIVIDUALS
(Employers with 100 or more Employees)

This Plan will be the primary payor and Medicare will be the secondary payor for the payment of benefits for disabled individuals who are "currently working" (as defined by Medicare) covered employees or covered dependents of such employees.

Effective August 10, 1993, Medicare will be the primary payor and this Plan will be the secondary payor for the payment of benefits for disabled individuals who are not "currently working" (as defined by Medicare) covered employees or covered dependents of such employees. The benefits of Medicare and this Plan

are fully coordinated to provide benefits totaling not more than the actual expenses incurred.

This provision does not apply to "currently working" disabled individuals entitled to Medicare because of end stage renal disease (ESRD) during the period of time which Medicare is the primary payor and the Plan is the secondary payor as prescribed by law. This provision intends to comply with the OMBRA Act of 1986 and 1993.

CERTAIN DISABLED INDIVIDUALS
(Employers with less than 100 Employees)

For covered individuals who are totally disabled who are eligible for Medicare benefits, both Medicare Part A (hospital portion) and Medicare Part B (doctors portion) will be considered the primary payor in computing benefits under this Plan. The benefits of Medicare and this Plan are fully coordinated to provide benefits totaling not more than the actual expenses incurred.

INDIVIDUALS WITH END STAGE RENAL DISEASE

For covered individuals with end stage renal disease (ESRD) who are eligible for Medicare benefits, this Plan will be the primary payor and Medicare will be the secondary payor for the payment of benefits for the period of time specified by law, after which time Medicare will become the primary payor and this Plan will be the secondary payor. Both Medicare Part A (hospital portion) and Medicare Part B (doctors portion) will be considered in computing benefits under this Plan. The benefits of Medicare and this Plan are fully coordinated to provide benefits totaling not more than the actual expenses incurred. This provision intends to comply with the OMBRA Act of 1993.

COBRA

CONTINUATION COVERAGE RIGHTS UNDER COBRA

The following contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This generally explains COBRA continuation coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This information is included as part of the Plan Document/Summary Plan Description. For additional information about your rights and obligations under the Plan and under the federal law, you should contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event". Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary". You, your spouse and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage (the full cost means the Employee and Employer cost of coverage) before the group health coverage is continued **and** monthly payments must be made in order to continue the coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other then gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because any of the following Qualifying Events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment end for any reason other than gross misconduct;
- Your spouse becomes entitled to Medicare benefits (Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

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

Sometimes, filing a proceeding in bankruptcy under title eleven (11) of the United States Code can be a Qualifying Event, but only if the Plan offers retiree coverage. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or the reduction of hours of employment, death of employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the employee becoming entitled to Medicare benefits (Part A, Part B or both), the Employer

must notify the Plan Administrator within thirty (30) days of any of these events.

You Must Give Notice Of Some Qualifying Events

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator in writing within sixty (60) days after the Qualifying Event occurs. Your written notice should include the date of the Qualifying Event. If you or your spouse are notifying the Plan Administrator of a divorce or legal separation, you or your spouse should provide a copy of the legal separation papers or divorce decree. You must provide this notice to: **Danville Area Community College.**

If you fail to give written notice with the sixty (60) day time period, the spouse and/or dependent child shall lose the right to elect COBRA continuation coverage.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the employee, your divorce or legal separation, a dependent child's losing eligibility as a dependent or loss of coverage due to Medicare Entitlement (under Part A, Part B or both), COBRA continuation lasts for up to a total of thirty-six (36) months.

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight

(28) months after the date of the Qualifying Event (thirty-six (36) months minus eight (8) months).

Otherwise, when the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability Extension Of The Eighteen (18) Month Period

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in writing in a timely fashion, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The disability would have to have started some time before the sixtieth (60th) day of COBRA continuation coverage and last at least until the end of the eighteen (18) month period of COBRA continuation coverage. A copy of the Notice of Award from the Social Security Administration **must** be submitted to the Plan Administrator and the COBRA Administrator within sixty (60) days of receipt of Notice of Award and before the end of the eighteen (18) month period of COBRA continuation coverage.

Second Qualifying Event Extension Of Eighteen (18) Month Period

If your COBRA covered family members experience another COBRA Qualifying Event within the first eighteen (18) months of COBRA continuation coverage, the spouse and dependent children in your family may be eligible to receive up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the secondary event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, or is divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. In all cases, the eighteen (18) month extension is available only if the second Qualifying Event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

The following example shows how the second Qualifying Event rule works. Former employee A elects eighteen (18) months of COBRA continuation coverage for the entire family. After the first six (6) months of COBRA continuation coverage, former employee A becomes entitled to Medicare (Part A, Part B or both). If former employee A were still actively employed,

entitlement to Medicare **would not** result in a loss of coverage under the Employer's group health plan. The additional eighteen (18) month extension is not available for the former employee's spouse and dependents because if Medicare entitlement had occurred during active employment there would have been no loss of Employer group health plan coverage.

In all of these cases, you must notify the Plan Administrator within sixty (60) days of the second Qualifying Event.

Early Termination Of COBRA Continuation Coverage

COBRA continuation coverage will terminate before the end of the maximum period if:

- The Qualified Beneficiary fails to make the required contributions when due;
- The Qualified Beneficiary becomes covered under another group health plan after the date of the COBRA election;
- The Qualified Beneficiary becomes entitled to Medicare benefits (Part A, Part B or both) after electing COBRA continuation coverage; or
- The Employer ceases to provide any group health plan for its employees.

How Can You Elect COBRA Continuation Coverage?

To elect COBRA continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each Qualified Beneficiary has a separate right to elect COBRA continuation coverage. For example, the employee's spouse may elect COBRA continuation coverage even if the employee does not. COBRA continuation coverage may be elected for only one, several or for all dependent children who are Qualified Beneficiaries. A parent may elect to continue COBRA continuation coverage on behalf of any dependent children. The employee or the employee's spouse can elect COBRA continuation coverage on behalf of all of the Qualified Beneficiaries.

You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within thirty (30) days after your group health coverage ends because of the Qualifying Event listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if you elect COBRA continuation coverage for the maximum time available to you.

How Much Does COBRA Continuation Coverage COST?

Generally, each Qualified Beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount a Qualified Beneficiary may be required to pay may not exceed one hundred two percent (102%) (or, in the case of an extension of COBRA continuation coverage due to a disability, one hundred fifty percent (150%) of the cost to the Group Health Plan (including both employer and Employee contributions) for coverage of a similarly situated plan Participant or Beneficiary who is not receiving COBRA continuation coverage.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

When and How Must Payment for COBRA Continuation Coverage be Made?

First Payment For COBRA Continuation Coverage

If you elect COBRA continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA continuation coverage not later than forty-five (45) days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for COBRA continuation coverage in full within forty-five (45) days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator or Plan Administrator to confirm

the correct amount of your first payment.

Periodic Payments For COBRA Continuation Coverage

After you make your first payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each Qualified Beneficiary is shown on the Election Notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for COBRA continuation coverage is due on the first day of each month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Grace Periods For Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of thirty (30) days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

Your first payment and all periodic payments for COBRA continuation coverage should be sent to the Plan Administrator or COBRA Administrator.

If You Have Questions

Questions concerning your Plan or your COBRA continuation rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and

Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefit Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa

Keep Your Plan Informed

In order to protect your family's rights, you should keep the Plan Administrator informed of any change in marital status, dependent status or address change. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Danville Area Community College
2000 East Main Street
Danville, IL 61832
(217) 443-3722

DEFINITIONS OF TERMS

The terms are capitalized to highlight their use.

ACCIDENT - An injury which is:

1. Caused by an event which is sudden and unforeseen; and

2. Exact as to time and place of occurrence.

ADVERSE BENEFIT DETERMINATION – A denial, reduction or termination of, a recession of coverage, or failure to provide or make payment (in whole or in part) for, a benefit, or to provide or make payment that is based on a determination of Participant's or Beneficiary's eligibility to participate in a plan, with respect to Group Health Plans. Included is failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or investigational or not Medically Necessary or appropriate.

ALCOHOL, CHEMICAL DEPENDENCY OR DRUG ADDICTION TREATMENT FACILITY - A facility (other than a hospital) whose primary function is the treatment of alcoholism, chemical dependency or drug addiction and which is approved by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) or is duly licensed by the appropriate governmental authority to provide such services.

ALTERNATE RECIPIENT – Any child of a participant who is recognized under a medical child support order as having a right to enrollment under a Group Health Plan. A person who is an Alternate Recipient under a QMCSO shall be considered a beneficiary under the Plan.

AMBULANCE - Emergency transportation in a specially equipped certified vehicle from the Covered Person's home, the scene of an accident or a medical emergency to a hospital, between hospitals, between a hospital and an extended care facility or from a hospital or an extended care facility to the Covered Person's home.

AMBULATORY SURGICAL CENTER - A specialized facility or a facility affiliated with a Hospital which is approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or licensed in accordance with the applicable laws in the jurisdiction in which it is located and is established, equipped and operated primarily for the purpose of performing surgical procedures on an ambulatory basis.

APPLICABLE PREMIUM - The cost to the Plan for the continuation coverage, calculated in accordance with Section 604 of ERISA.

ASSIGNMENT OF BENEFITS - Assignment of Benefits occurs when the Covered Person files a claim and authorizes the Plan to pay the Physician or Hospital directly.

BENEFICIARY - The person named to receive the Covered Person's Life Insurance Benefit and/or Accidental Death Benefit, or any person or persons (including but not limited to, an individual, trust, estate, executor, administrator or fiduciary, whether corporate or otherwise) designated to receive benefits pursuant to the terms of the Plan or any insurance policies, contracts or administrative service agreements, constituting the Plan.

BIRTHING CENTER - A specialized facility or a facility affiliated with a hospital which:

1. Provides twenty-four (24) hour a day nursing service by or under the supervision of registered graduate nurses (R.N.) and certified nurse midwives; and

2. Is staffed, equipped and operated to provide:

    a. Care for patients during uncomplicated pregnancy, delivery, and the immediate postpartum period;

    b. Care for infants born in the center who are normal or have abnormalities which do not impair function or threaten life; and

    c. Care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life pending transfer to a hospital.

CALENDAR YEAR - For the purposes of this Plan, a length of time beginning on January 1 and ending on December 31.

CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) - A person who:

1. Is a graduate of an approved school of nursing and is duly licensed as a registered nurse;

2. Is a graduate of an approved program of nurse anesthesia accredited by the Council of Certification of Nurse Anesthetists or its predecessors;

3. Has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and

4. Is recertified every two (2) years by the Council on Recertification of Nurse Anesthetists.

CHILD - The Employee's Children under twenty-six (26) years of age. The term "Child" shall include natural Children, a legally adopted Child (including the period of probation when the Child is placed with the adopting parents), a step-Child, a Child related to the Employee by blood or marriage and for whom the Employee has assumed legal guardianship, or a Child whom the Employee must cover due to a Qualified Medical Child Support Order (QMCSO), subject to the conditions and limits of the law.

An unmarried Child who is physically or mentally incapable of self-support upon attaining age twenty-six (26), may be covered under the health care benefits, while remaining incapacitated, subject to the Covered Employee's own coverage continuing in effect. Such Child will be considered a Covered Dependent if he was Disabled prior to his twenty-sixth (26th) birthday.

To continue Covered Dependent status of a child under this provision, proof of incapacity must be received by the College within sixty (60) days after coverage would otherwise terminate. Additional proof will be required from time to time

Evidence satisfactory to the College of dependent eligibility under the Plan may be requested; for example, birth records or Federal Income Tax returns.

CHRISTIAN SCIENCE NURSE – A nurse who is listed in a Christian Science Journal at the time the services are given and who: (a) has completed nurse's training at a Christian Science Benevolent Association Sanitarium; or (b) is a graduate of another School of Nursing; or (3) had three (3) consecutive years of Christian Science Nursing, including two (2) years of training.

CHRISITAN SCIENCE PRACTITIONER – An individual who is listed as such in the Christian Science Journal at the time the medical services are provided and who provides appropriate treatment in lieu of treatment by a medical doctor.

CIVIL UNION PARTNER – The person who has entered into a legally granted Civil Union with the Employee while the Employee is covered under this Plan.

CLAIMS ADMINISTRATOR - Benefit Administrative Systems, L.L.C.

CODE - The Internal Revenue Code of 1986, as amended from time to time, and the regulations thereunder.

CO-INSURANCE - That portion of Covered Medical Expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any out-of-pocket expenses in excess of the deductible which are to be paid by the Employee.

COLLEGE – Danville Area Community College.

CONTINUATION PREMIUM - The amount charged by the Plan to a Qualified Beneficiary for a specified period of continuation coverage under the Plan.

COORDINATION OF BENEFITS - If an individual is covered by another group plan of health care, this Plan will coordinate its payment of benefits with the other plan to allow as complete a claim reimbursement as possible without providing duplicate payments.

CO-PAYMENT - That portion of Covered Medical Expenses which must be paid by or on behalf of the Covered Person incurring the expense.

COSMETIC SURGERY - Surgery that is intended to improve the appearance of a patient or preserve or restore a pleasing appearance. It does not mean surgery that is intended to correct normal functions of the body. This does not include reconstructive surgery resulting from an Illness or Injury.

COVERED EMPLOYEE - An Employee who has satisfied all applicable Eligibility provisions of the Plan and for whom coverage has not terminated.

COVERED PERSON - A Covered Employee or Covered Dependent as herein described.

CUSTODIAL CARE - Care which is not a necessary part of medical treatment for recovery but provides services and support to assist the Covered Person in the activities of daily living including, but not limited to, walking, bathing or feeding. It also consists of care which any person may be able to perform with minimal instruction, including, but not limited to, recording temperature, pulse and respirations; suctioning of the pharynx; administering and monitoring feeding systems or drugs and medicines which are usually self-administered.

DEDUCTIBLE - The amount of Covered Medical and/or Dental Expenses that a Covered Person must pay before he can receive a benefit payment under the Medical and/or Dental Expense Benefits.

DENTIST - A duly licensed Dentist practicing within the scope of his license and any other Physician furnishing any dental services which he is licensed to perform.

DENTAL HYGIENIST - A person who is currently licensed to practice dental hygiene by the governmental authority having jurisdiction over the licensing and practice of Dental Hygiene, and who works under the direct supervision and direction of a Dentist.

DEPENDENT - For the purposes of this Plan, the Employee's Spouse, Civil Union Partner and Children to the age of twenty-six (26), (see definition of "Child"), and Disabled Children, if such incapacity occurred prior to the limiting age specified.

DIALYSIS FACILITY - A facility (other than a Hospital) whose primary function is the provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

DISABLED -

1. The Covered Person's complete inability as an active employee, to perform any and every duty pertaining to his occupation or employment or for any occupation for wage or profit, or
2. The Covered Dependent's complete inability to perform the normal activities of a person of like age and sex, or
3. The Covered Person's complete inability, as a retired employee, to perform the normal activities of a person of like age and sex.

DURABLE MEDICAL EQUIPMENT - Only that equipment and those supplies that:

1. Are primarily and customarily used to serve a medical purpose;
2. Would not be generally useful to a person in the absence of an Illness or Injury;
3. Are designed for repeated use; and
4. Either:
    a. Are medically necessary to:
        i. Treat an Illness or Injury;
        ii. Effect improvement of a Covered Person's medical condition; or
        iii. Arrest or retard deterioration of a Covered Person's medical condition; or
    b. Are alternatives to chair or bed confinement.

ELECTIVE SURGERY - Surgery that is not emergency in nature or is not performed to correct a life-threatening situation.

EMERGENCY DENTAL CARE - An urgent, unplanned diagnostic visit and/or alleviation of acute or unexpected Dental condition.

EMERGENCY MEDICAL CARE - The initial treatment, including necessary related diagnostic services, of the unexpected and sudden onset of a medical condition manifesting itself by symptoms severe enough that the

absence of immediate treatment could result in serious and/or permanent medical consequences.

EMPLOYEE - The word "Employee" as used herein shall mean any person employed and compensated for services by the College on a regular full-time permanent basis.

ERISA - The Employee Retirement Income Security Act of 1974, as amended. As a participant of the Plan, the Covered Person has a number of rights under ERISA as outlined.

EXPERIMENTAL - The use of any treatment, procedure, facility, equipment, drug, device or supply which is not accepted as standard medical treatment of the condition being treated, or any such items requiring Federal or other government approval which has not been 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 views 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 by the Plan Administrator in its sole discretion within this definition.

EXTENDED CARE FACILITY (CONVALESCENT FACILITY) -

1. A Skilled Nursing Facility, as the term is defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare, except for a Skilled Nursing Facility which is part of a hospital, as defined, or;

2. An institution which fully meets all of the following tests:

    a. It is operated in accordance with the applicable laws of the appropriate governmental authority where it is located.

    b. It is under the supervision of a licensed Physician, or Registered Nurse (R.N.), who is devoting full-time to such supervision.

    c. It is regularly engaged in providing room and board and continuously provides twenty-four (24) hour-a-day skilled nursing care of ill and injured persons at the patient's expense during the convalescent stage of an injury or illness.

d. It maintains a daily medical record of each patient who is under the care of a duly licensed Physician.

e. It is authorized to administer medication on the order of a duly licensed Physician.

f. It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

GENERIC DRUGS - Prescription drugs and prescription medicines which are not protected by a trademark.

GROUP HEALTH PLAN - Any plan or arrangement constituting a group health plan under Section 607(l) of ERISA.

HEALTH BENEFITS - Benefits provided under a Group Health Plan for medical care as defined pursuant to Section 213(d) of the Code.

HOME HEALTH AIDE - A person who provides care of a medical or therapeutic nature and reports to and is under the direct supervision of a Home Health Care Agency.

HOME HEALTH CARE AGENCY - Is either:

1. An Agency that is certified to participate as a Home Health Care Agency under Medicare;

2. A hospital that has a valid operating certificate and is certified by the appropriate authority to provide home health services;

3. An agency licensed as such, if such licensing is required, in the state in which such Home Health Care is delivered; or

4. A public agency or private organization or subdivision of such that meets the following requirements:

   a. It is primarily engaged in providing nursing and other therapeutic services;

   b. It is duly licensed, if such licensing is required, by the appropriate licensing authority, to provide such services;

   c. It is federally certified as a Home Health Care Agency.

HOME HEALTH CARE PLAN - A Home Health Care program, prescribed in writing by a person's Physician, for the care and treatment of the person's Illness or Injury in the person's home. In the Plan, the Physician must certify that an inpatient stay in a Hospital, a Convalescent Nursing Home, or an Extended Care Facility would be required in the absence of the services and supplies provided as part of the Home Health Care Plan. The Home Health Care Plan must be established in writing no later than fourteen (14) days after the start of the Home Health Care. An inpatient stay is one for which a room and board charge is made.

HOSPICE CARE -

1. A coordinated, interdisciplinary Hospice-provided program meeting the physical, psychological, spiritual and social needs of dying individuals, and

2. Consists of palliative and supportive medical, nursing and other health services provided through home or inpatient care during the illness to a Covered Person who has no reasonable prospect of cure and as estimated by a Physician, has a life expectancy of fewer than six (6) months; and consists of bereavement counseling for members of such Covered Person's immediate family.

HOSPICE CARE FACILITY - Is either:

1. A free-standing facility which is fully staffed and equipped to provide for the needs of the terminally ill (and their families); or

2. An inpatient facility which is part of a hospital but designated as a Hospice unit or is an adjacent facility, administered by a Hospital and designated as a Hospice unit.

   A Hospice Care Facility must be approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or must meet the standards of the National Hospice Organization (NHO) and the appropriate licensing authority, if such licensing is required.

HOSPITAL - A legally operated institution which meets either of these tests:

1. Is accredited as a Hospital under the Hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or
2. Is a Hospital, as defined, by Medicare, which is qualified to participate and eligible to receive payments under an in accordance with the provisions of Medicare, or
3. Is supervised by a staff of physicians, has twenty-four (24) hour-a-day nursing services, and is primarily engaged in providing either:
    a. General inpatient medical care and treatment through medical, diagnostic and major surgical facilities on its premises or under its control, or
    b. Specialized inpatient medical care and treatment through medical and diagnostic facilities (including x-ray and laboratory) on its premises, or under its control, or through a written agreement with a Hospital (which itself qualifies under this definition) or with a specialized provider of these facilities.
    c. A psychiatric Hospital primarily engaged in diagnosing and treating mental illness, if it meets all of the requirements set forth in clause (a) other than the major surgery requirement.
    d. A free standing treatment facility, other than a Hospital, whose primary function is the treatment of alcoholism or drug abuse provided the facility is duly licensed by the appropriate governmental authority to provide such service, and is accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Hospital Association.
    e. A rehabilitative Hospital which is an institution operated primarily for the purpose of providing the specialized care and treatment for which it is duly licensed, and which meets all of the requirements of an accredited Hospital.

In no event will the term "Hospital" include a nursing home or an institution or part of one which:

a. Is primarily a facility for convalescence, nursing, rest, or the aged, or
b. Furnishes primarily domiciliary or custodial care, including training in daily living routines, or
c. Is operated primarily as a school.

ILLNESS - A bodily disorder, disease, pregnancy, or mental infirmity. All bodily injuries sustained by an individual in a single accident or all illnesses which are due to the same or related cause or causes will be deemed one illness.

INCURRED EXPENSE - A charge which the Covered Person is legally obligated to pay and shall be deemed to be incurred on the date the purchase is made or on the date the service is rendered for which the charge is made. Anticipated expenses are not incurred expenses.

INJURY - An unforeseen happening to the body requiring medical attention and includes all related symptoms and recurrent conditions resulting from the accident.

INPATIENT - A person receiving room and board while undergoing treatment in a Hospital, Hospice or other covered facility.

INTENSIVE CARE UNIT - A section, ward or wing within a hospital which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by professional nurses or other highly trained personnel, excluding any hospital facility maintained for the purposes of providing normal post-operative recovery treatment or services.

INTENSIVE OUTPATIENT PROGRAM – Services offered to address treatment of mental health or substance abuse and could include individual, group, or family psychotherapy and adjunctive services such as medication monitoring. Program services are provided at least two (2) hours per day or six (6) hours per week.

LEAVE OF ABSENCE - A period of time during which the employee does not work but which is of stated duration after which time the employee is expected to return to active full-time work.

LICENSED PRACTICAL NURSE/LICENSED VOCATIONAL NURSE - An individual who has received specialized nursing training and practical nursing experience and who is licensed to perform such service, other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

LIFETIME - When used in reference to benefit maximums and limitations, "Lifetime" is understood to mean while covered under this Plan. Under no circumstances does "Lifetime" mean during the lifetime of the Covered Person.

MEDICAL EXPENSE BENEFIT - After satisfaction of the applicable deductible, benefits will be provided for covered medical expenses for an illness or injury in a Calendar Year.

MEDICALLY NECESSARY/MEDICAL NECESSITY - Services and supplies which are determined by the Plan Administrator, or its authorized agent to:

1. Be appropriate, consistent and necessary for the symptoms and diagnosis and treatment of a medical condition;

2. Be in accordance with standards of good medical practice within the organized medical community;

3. Not be solely for the convenience of the patient, Physician or other health care provider; and

4. Be the most appropriate and cost effective supply or level of service which can be safely provided.

   For hospitalizations, this means that acute care as an inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's medical condition, and that safe and adequate medical care cannot be received as an outpatient or in a less intensified medical setting.

   The fact that the service is prescribed, ordered, recommended or approved by a Physician does not, of itself, mean the service is Medically Necessary. In an effort to make treatment convenient, to follow the wishes of the patient or the patient's family, to investigate the use of unproven treatment methods, or to comply with local Hospital practices, a Physician may suggest or permit a method of providing care that is not Medically Necessary.

MEDICARE - Title XVIII of the Social Security Act of 1965, as amended from time to time, and the regulations thereunder.

NETWORK PROVIDER - A health care provider who agrees to provide medically necessary care and treatment at a negotiated rate.

NOTICE OR NOTIFICATION – The ability to reasonably ensure actual receipt of the materials and specifically includes the normal mailing through the U. S. Mail.

OCCUPATIONAL THERAPY –Treatment rendered as a part of a physical medicine and rehabilitation program to improve functional impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. Benefits are not provided for diversion, recreational and vocational therapies (such as hobbies, arts & crafts).

ORTHOTIC APPLIANCE – An external device intended to correct any defect in form or function of the human body.

OUT-OF-POCKET MAXIMUM - The maximum covered expense, including any Deductibles, that a Covered Person or family must pay before the Plan pays 100% of the balance of eligible medical expenses for such person or family for the remainder of the Calendar Year.

OUTPATIENT – When a Covered Person receives diagnosis, treatment or twenty-three (23) hour observation in a hospital or treatment facility but is not admitted as an inpatient.

PARTIAL HOSPILTAIZATION PROGRAM – Services offered to address the treatment of mental health or substance abuse and could include individual, group, or family psychotherapy. Services are medically supervised and essentially the same intensity as would be provided in a hospital setting except that the patient is in the program less than twenty-four (24) hours per day. Program services are provided at least four (4) hours per day and at least three (3) days per week.

PARTICIPANT - An Employee of the Plan Administrator who participates in the Plan.

PHARMACY - Any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPY –Treatment by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound, manipulation and subluxation; as well as tests of measurement requirements to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following illness, injury or loss of body parts. Treatment must be for acute conditions

where rehabilitation potential exists and the skills of a Physician or other professional are required.

PHYSICIAN - A medical doctor (M.D.), an osteopath (D.O.), a dentist or dental surgeon (D.D.S., D.M.D.), a podiatrist (D.P.M.), a chiropractor (D.C.), a psychologist (Ph.D., Psy.D.) or an optometrist (D.O.) or other medical professional who is duly licensed under the laws of the appropriate governmental authority to practice medicine, to the extent they, within the scope of their license are permitted to perform the services provided by this Plan. A Physician shall not include the Covered Person or any close relative of the Covered Person.

PLAN – Danville Area Community College Employee Health Care Plan.

PLAN ADMINISTRATOR – Community College Insurance Cooperative, the entity 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 services related to the Plan.

PLAN DOCUMENT - The legal document according to which the Plan is administered and governed.

PRE-ADMISSION TESTING - X-rays, laboratory examinations or other tests performed in the outpatient department of a hospital or other facility prior to outpatient treatment or to confinement as an inpatient provided:

1. Such tests are related to the scheduled hospital confinement;

2. Such tests have been ordered by a duly qualified physician after a condition requiring such confinement has been diagnosed and hospital admission has been requested by the physician, approved by the Utilization Review Service, and confirmed by the hospital; and

3. The Covered Person is subsequently admitted to the hospital, or the confinement is canceled or postponed because a hospital bed is unavailable, or under the directions of the attending physician, or because there is a change in the patient's condition which precludes the confinement.

PREFERRED PROVIDER - A health care provider who agrees to provide medically necessary care and treatment at a negotiated rate under this Plan.

PREGNANCY – That physical state which results in childbirth, abortion or miscarriage, and any medical complications arising out of, or resulting from, such state.

PROSTHETIC DEVICE –A device which:

1. Replaces all or part of a missing body organ and its adjoining tissue; or

2. Replaces all or part of the function of a permanently useless or malfunctioning organ.

PSYCHIATRIC DISORDER - Neuroses, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind.

PSYCHIATRIC TREATMENT - Treatment or care for:

1. A mental or emotional disease or disorder;

2. A functional nervous disorder; or

3. Psychological effects of Substance Abuse.

QUALIFIED BENEFICIARY - Any Beneficiary who is a qualified beneficiary as defined under Section 607(3) of ERISA.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) – A QMCSO is a medical child support order issued under State Law that creates or recognizes the existence of an "Alternate Recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan.

Enrollment of a child may not be denied on the ground that:

1. The child was born out of wedlock;

2. The child is not claimed as a dependent on the participant's Federal income tax return;

3. The child does not reside with the participant or in the plan's services area; or

4. Because the child is receiving benefits or is eligible to receive benefits under the State Medicaid plan. If the plan requires that the participant be enrolled in order for the child(ren) to be enrolled, and the participant is not currently enrolled, the Plan Administrator must enroll both the participant

and the child(ren). All enrollments are to be made without regard to open season restrictions.

REASONABLE AND CUSTOMARY FEE LIMITATION - An amount measured and determined by comparing the actual charge with the charges customarily made for similar services and supplies to individuals of similar medical conditions in the locality concerned. The term "locality" means a county or such greater geographically significant area as is necessary to establish a representative cross section of persons, or other entities regularly furnishing the type of treatment, services or supplies for which the charge was made.

REGISTERED NURSE - A professional nurse who has the right to use the title Registered Nurse (R.N.) other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

RELEVANT DOCUMENT – A document, record or other information that was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination (whether or not the information was relied upon to make a benefit determination); demonstrates compliance with the administrative process and safeguards required in making the benefit determination; or in the case of a group health or disability plan, information that constitutes a statement of policy with respect to the denied treatment option or benefit for the claimant's diagnosis.

RESIDENTIAL TREATMENT FACILITY - Means a facility (other than a hospital) whose primary function is the treatment of a mental or emotional disease or disorder, functional nervous disorder, the treatment of alcoholism, chemical dependency or drug addiction and which is duly licensed by the appropriate governmental authority to provide such services.

ROOM AND BOARD - Services regularly furnished by the Hospital as a condition of occupancy, but not including professional services.

SOUND NATURAL TOOTH - A tooth which:

1. Is free of decay, but may be restored by fillings;

2. Has a live root; and

3. Does not have a cap or a crown.

SPEECH THERAPY –Active treatment for improvement of an organic medical condition causing a speech impairment. Treatment must be either post-operative or for the convalescent stage of an illness or injury.

SPOUSE - The person who is legally married to the Employee while the Employee is covered under this Plan. ***The term Spouse does not include ex-spouses or common-law spouses.***

SUBSTANCE ABUSE - An excessive use of alcohol and/or drugs that results in physiological and/or psychological dependency of such substances.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ) - Pain, swelling, clicking, grinding, popping, dislocation, locking, malposition, bite discrepancies or other pathological conditions which create a loss or decrease of function in or around one or both of the jaw joints.

TERMINALLY ILL PATIENT - A person with a life expectancy of six (6) months or less as certified in writing by the attending physician.

TREATMENT PLAN - A Dentist's report, on a form satisfactory to the College, which:

1. Itemizes the dental services recommended by him for the necessary and customary dental care of an Insured; and

2. Shows his charge for each dental service; and

3. Is accompanied by supporting pre-operative X-rays or other appropriate diagnostic materials as required by the College.

WORKERS' COMPENSATION - A fund administered under any Workers' Compensation, Occupational Diseases Act or Law or any other act or law of similar purpose to which the College contributes, which provides the employee with coverage for job-related accidental injuries and illnesses.

HOW TO SUBMIT A CLAIM

MEDICAL CLAIMS

Every medical claim must include a Physician's statement specifying the nature of the illness or injury for which reimbursement is requested. The Claims Administrator will accept such a diagnostic statement on any form which your doctor prefers to use. ***WITHOUT A DIAGNOSIS, YOUR CLAIM CANNOT BE PROCESSED.***

All bills, except those for drugs, must indicate the patient's full name, the nature of the illness or injury, the date(s) of service, the type(s) of service and the charge for each service and the name, address and tax identification number of the provider.

When prescription drugs are purchased through the Prescription Drug Plan, a claim submission is not necessary. Your only responsibility is to pay the applicable co-payment at the time you purchase the prescription.

Should there be a primary insurance carrier for a member of your family, it is important to submit a copy of the itemized claim with a copy of the primary carrier's Explanation of Benefits statement indicating payment or denial of the charges.

MEDICARE CLAIMS

A Medicare claim is submitted as previously explained; however, when you submit the claim, be sure you also submit the Explanation of Benefits (EOB) which you receive from Medicare. The Claims Administrator may be unable to accurately determine benefits payable under the Plan without the Medicare EOB.

DENTAL CLAIMS

Discuss the treatment plan with your Dentist. If the services will exceed $600, ask your Dentist to submit a "Pre-Treatment Estimate." The Claims Administrator will advise your Dentist of the amount the Plan can pay toward your treatment.

If the services are for emergency treatment or less than $600, a treatment plan is not required.

WHERE TO SUBMIT A CLAIM

Completed claim forms and itemized bills should be submitted to the address indicated on your Health Benefit I.D. Card.

ALWAYS RETAIN A COPY FOR YOUR RECORDS.

TIMELY SUBMISSION OF CLAIMS

All charges must be submitted no more than one (1) year from the ending date of the calendar year in which the charge was incurred, except that failure to submit within the stated time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to submit such claim in a timely manner and that the claim was submitted as soon as was reasonably possible.

Under the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

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

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

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

- Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

  - The Plan Administrator determines that the course of treatment should be reduced or terminated; or

  - The Covered Person requests extension of the course of treatment beyond that which the Plan Administrator has approved.

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

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

When Health Claims Must Be Filed
Post-service health claims must be filed with the Claims Administrator within one (1) year of the date charges for the service(s) incurred. Failure to file a claim within this time limit will not invalidate the claim provided that the Covered Person submits evidence satisfactory to the Plan Administrator that it was not reasonably possible to file the claim within the time limit. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Claims Administrator in accordance with the Plan's procedures.

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

Timing of Claim Decisions
The Plan Administrator shall notify the Covered Person, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

- Pre-service Urgent Care Claims*:*

  - If the Covered Person has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim.

- If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than seventy-two (72) hours after receipt of the claim. The Covered Person will be notified of a determination of benefits as soon as possible, but not later than seventy-two (72) hours, taking into account the medical exigencies, after the earliest of:
  - The Plan's receipt of the specified information; or
  - The end of the period afforded the Covered Person to provide the information.

- Pre-service Non-urgent Care Claims*:*
  - If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.
  - If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than five (5) days after receipt of the claim. The Covered Person will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Covered Person (if additional information was requested during the extension period).

- Concurrent Claims*:*
  - Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Covered Person of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Covered Person will be notified sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

- Request by Covered Person Involving Urgent Care. If the Plan Administrator receives a request from a Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim, as long as the Covered Person makes the request at least seventy-two (72) hours prior to the expiration of the prescribed period of time or number of treatments. If the Covered Person submits the request with less than seventy-two (72) hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

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

- Post-service Claims:

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

  - If the Covered Person has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Covered Person will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Covered Person will be notified of the determination by a date agreed to by the Plan Administrator and the Covered Person.

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

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

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

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

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Covered Person with a notice, either in writing or electronically (or, in the case of Pre-service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice), containing the following information:

- A reference to the specific portion(s) of the Plan Document and Summary Plan Description upon which a denial is based;

- Specific reason(s) for a denial;

- A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Covered Person's right to bring a civil action under section 502(a) of ERISA (if applicable) following an Adverse Benefit Determination on final review;

- A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents,

records and other information relevant to the Covered Person's claim for benefits;

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

- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Covered Person, free of charge, upon request);

- In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, or a statement that such explanation will be provided to the Covered Person, free of charge, upon request; and

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

Appeals of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Covered Person believes the claim has been denied wrongly, the Covered Person may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Covered Person with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

- Covered Persons at least one hundred eighty (180) days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination and one hundred eighty (180) days to appeal a second Adverse Benefit Determination;

- Covered Persons the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named

fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

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

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

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

- That a Covered Person will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits in possession of the Plan Administrator or the Claims Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances; and

- In an Urgent Care claim*,* for an expedited review process pursuant to which:

  - A request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Covered Person*;* and

  - All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan

and the Covered Person by telephone, facsimile or other available similarly expeditious method.

First Appeal Level

Requirements for First Appeal

The Covered Person must file the first appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) within one hundred eighty (180) days following receipt of the notice of an Adverse Benefit Determination. For Pre-service Urgent Care Claims, if the Covered Person chooses to orally appeal, the Covered Person may telephone:

Danville Area Community College
(217) 443-3722

To file an appeal in writing, the Covered Person's appeal must be addressed as follows and mailed or faxed as follows:

Danville Area Community College
2000 East Main Street
Danville, IL 61832
(217) 443-8589

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

- The name of the Employee/Covered Person;
- The Employee/Covered Person's social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Covered Person will lose the right to raise factual arguments and theories which support this claim if the Covered Person fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

- Any material or information that the Covered Person has which indicates that the Covered Person is entitled to benefits under the Plan.

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

Timing of Notification of Benefit Determination on First Appeal

The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

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

- Pre-service Non-urgent Care Claims*:* Within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the appeal.

- Concurrent Claims*:* The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service non-urgent or Post-Service.

- Post-service Claims*:* Within a reasonable period of time, but not later than thirty (30) days after receipt of the appeal.

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

Manner and Content of Notification of Adverse Benefit Determination on First Appeal

The Plan Administrator shall provide a Covered Person with notification, with respect to Pre-service Urgent Care Claims*,* by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

- The specific reason or reasons for the denial;

- Reference to the specific portion(s) of the Plan Document and Summary Plan Description on which the denial is based;

- The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;

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

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Covered Person upon request;

- If the Adverse Benefit Determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided free of charge upon request;

- A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's review procedures and the time limits applicable to the procedures;

- For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claims;

- A statement of the Covered Person's right to bring an action under section 502(a) of ERISA (if applicable), following an Adverse Benefit Determination on final review; and

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

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

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal
Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the Covered Person has one hundred eighty (180) days to file a second appeal of the denial of benefits. The Covered Person again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Covered Person has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Covered Person's second appeal must be in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal
The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

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

- Pre-service Non-urgent Care Claims*:* Within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the second appeal.

- Concurrent Claims*:* The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.

- Post-service Claims*:* Within a reasonable period of time, but not later than thirty (30) days after receipt of the second appeal.

- Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan,

without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan's response to a second appeal as a first appeal, except for:

- A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is needed;
- A description of the Plan's review procedures and the time limits applicable to the procedures; and
- For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claim. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination

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

Legal Action

All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within three (3) years after the Plan's claim review procedures have been exhausted.

External Review

When a Covered Person has exhausted the internal appeals process outlined above, the Covered Person has a right to have that decision reviewed by independent health care professionals who has no association with the Plan, or the Plan Administrator. If the Adverse Benefit Determination involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested, you may submit a request for external review within **four (4) months** after receipt of a denial of benefits. For standard external review, a decision will be made within

forty-five (45) days of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of the denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is *experimental* or investigation, you also may be entitled to file a request for external review of our denial.

Please contact your Plan Administrator with any questions on your rights to external review.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR

Community College Insurance Cooperative Group Health Benefit Plan is the benefit plan of **Community College Insurance Cooperative**, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by **Community College Insurance Cooperative** to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, **Community College Insurance Cooperative** shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR

1. To administer the Plan in accordance with its terms.

2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

3. To decide disputes which may arise relative to a Covered Person's rights,

4. To prescribe procedures for filing a claim for benefits and to review claim denials.

5. To keep and maintain the Plan documents and all other records pertaining to the Plan.

6. To appoint a Claims Administrator to pay claims.

7. To perform all necessary reporting as required by ERISA.

8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION

The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

2. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

3. in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY

A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

2. the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

ASSETS UPON TERMINATION

The assets of the Plan will be used to pay for any benefits incurred prior to the termination of the Plan.

THE TRUST AGREEMENT

If this Plan is established under a Trust agreement, that agreement is made a part of the Plan. A copy of the appropriate agreement is available for examination by Employees and their Dependent(s) at the office of the Plan Administrator during normal business hours. Also, upon written request, the following items will be furnished to an Employee or Dependent:

A copy of the Trust agreement.

A complete list of employers and employee organizations sponsoring the plan.

Service of legal process may be made upon a Plan trustee.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

HEADINGS

The headings and subheadings of this Plan Document and Summary Plan Description have been inserted for convenience of reference and are to be ignored in any construction of the provisions thereof.

CONFORMITY WITH LAW

If any provision of the Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements thereof. This Plan intends to comply with any laws to which it is subject, whether or not this Plan has been specifically amended accordingly. These laws include ERISA, TEFRA, DEFRA, COBRA, The Family and Medical Leave Act of 1993 (FMLA), Budget Reconciliation Acts, HIPAA, MHPA, MNHPA, WHCRA, and any other laws which may have been enacted already or which may be enacted in the future.

LIABILITY OF OFFICERS AND EMPLOYEES

No officer or Employee of the Employer who may or may not be acting in a fiduciary capacity shall incur any personal liability of any nature for any act done or omitted to be done in good faith in connection with his duties in connection with the Plan, except in cases of wanton or willful negligence, or willful misconduct. Such officers or Employees shall be indemnified and saved harmless by the Employer from and against any liability to which any of them may be subjected by reason of any such good faith act or conduct in their official capacity, or by reason of conduct consistent with such prudent man rule acting in such fiduciary capacity, including all expenses reasonably incurred in their defense to the extent permitted by law.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the overpayment.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN EMPLOYEE RIGHTS UNDER ERISA

Covered Persons in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Covered Persons shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or 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. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Covered Persons, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Covered Persons and their beneficiaries. No one, including the Employer or any other person, may fire a Covered Person or otherwise discriminate against a Covered Person in any way to prevent the Covered Person from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

Enforce Your Rights

If a Covered Person's claim for a benefit is denied, in whole or in part, the Covered Person will receive a written explanation of the reason for the denial. The Covered Person has the right to have the Plan review and reconsider the claim. Under ERISA there are steps that the Covered Person can take to enforce the above rights. For instance, if the Covered Person requests materials from the Plan and does not receive them within thirty (30) days, that person may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Covered Person up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Covered Person has a claim for benefits which is denied or ignored, in whole or in part, that participant may file suit in state or federal court.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

Assistance with Your Questions

If the Covered Person has any questions about the Plan, he or she should contact the Plan Administrator. If the Covered Person has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Covered Person should contact either the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor at 200 Constitution Avenue, N.W., Washington, DC 20210.

RESCISSION OF COVERAGE

A rescission of your coverage means that the coverage may be legally voided back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage may only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan.

You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of rescission of your coverage. Once the appeal process is exhausted, you have the additional right to request an independent external review. Refer to the "CLAIMS REVIEW PROCEDURE" section for more information.

PRIVACY AND PROTECTED HEALTH INFORMATION

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Privacy and Security Rules promulgated thereunder, requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you upon enrollment and is available from the Human Resources Manager.

This Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to enter into agreements to protect the confidentiality of protected health information. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact the Human Resources Office. If you have questions about the privacy of your protected health information or if you wish to file a HIPAA complaint, please contact the Human Resources Office.

THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose Protected Health Information, or PHI. The following HIPAA definition of PHI applies to this Plan Amendment:

Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Plan Sponsor shall have access to PHI from the Plan only as permitted under this Plan Amendment or as otherwise required or permitted by HIPAA.

1. Use and Disclosure of PHI

The Group Health Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. Those activities include, but are not limited to, the following:

a. determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);

b. coordination of benefits;

c. adjudication of health benefit claims (including appeals and other payment disputes);

d. subrogation of health benefit claims;

e. establishing employee contributions;

f. risk adjusting amounts due based on enrollee health status and demographic characteristics;

g. billing, collection activities and related health care data processing;

h. claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

i. obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);

j. medical necessity reviews or reviews of appropriateness of care or justification of charges;

k. utilization review, including pre-certification, pre-authorization, concurrent review and retrospective review;

l. disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

m. reimbursement to the Plan.

Health Care Operations include, but are not limited to, the following activities:

a. quality assessment;

b. population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

c. rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;

d. underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or

health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);

e. conducting or arranging for medical review, legal services and auditing function, including fraud and abuse detection and compliance programs;

f. business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

g. business management and general administrative activities of the Plan, including, but not limited to:

    i. management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or

    ii. customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;

h. resolution of internal grievances; and

i. due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPPA or, following completion of the sale or transfer, will become a covered entity.

2. The Plan Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Personal Representative.

3. For Purposes of This Section, Danville Area Community College, is the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of certification from the Plan Sponsor that the plan documents have been amended to incorporate provisions included in sections 4 through 7.

4. With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions

The Plan Sponsor agrees to:

a. not use or further disclose PHI other than as permitted by the plan document or as required by law;

b. ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

c. not use or disclose PHI for employment related actions and decisions unless authorized by an individual;

d. not use or disclose PHI in connection with any other benefit or employee benefit of the Plan Sponsor unless authorized by an individual;

e. report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

f. make PHI available to an individual in accordance with HIPAA's access requirements;

g. make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

h. make available the information required to provide an accounting of disclosures in accordance with HIPAA;

i. make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

j. if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

5. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, the following is a list of individuals, by class, that may be given access to PHI:

a. Designated officers of the Company;

b. Designated personnel of the Human Resources Department;

c. Designated personnel of the Benefits Department;

d. Designated personnel of the Accounting Department; and

e. Employees designated from time to time by the Plan Sponsor.

6. Limitations of PHI Access and Disclosure

The persons described in section 5 may only have access to and use and disclose PHI for plan administrative functions that the Plan Sponsor performs for the Plan.

7. Noncompliance Issues

If the persons described in section 5 do not comply with this Plan Document, the Plan Sponsor has established a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

8. The Plan Sponsor has implemented administrative, technical and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, maintains or transmits on behalf of the Plan.

9. The adequate separation set forth in sections 5 through 7 are supported by reasonable and appropriate security measures.

10. The Plan Sponsor has, or shall, as the case may be, ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures.

11. The Plan Sponsor shall report to the Plan any security incident of which it becomes aware.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

This Employee Benefits Plan sponsored by Danville Area Community College is intended to comply with the Welfare Benefit Plan Provisions of the Employee Retirement Income Security Act of 1974. The following information together with the information contained in this Booklet is in accordance with the requirements of the Act.

Benefits are paid directly from the Plan through the Claims Administrator.

The Plan is a self-funded plan and the administration is provided through a third party Claims Administrator. The Plan is not insured.

Plan contributions for Employee coverage are made by the College and Employee.

Plan contributions for Dependent coverage are made by the Employee.

PLAN NAME — **Community College Insurance Cooperative**

PLAN NUMBER 501

TAX ID NUMBER 36-4455771

PLAN AMENDED AND RESTATED January 1, 2016

PLAN YEAR ENDS December 31

EMPLOYER INFORMATION
Danville Area Community College
2000 East Main Street
Danville, IL 61832
(217) 443-3722

PLAN ADMINISTRATOR
Community College Insurance Cooperative
17475 Jovanna Drive, 1B
Homewood, IL 60430
(708) 799-7400

NAMED FIDUCIARY
Community College Insurance Cooperative
17475 Jovanna Drive, 1B
Homewood, IL 60430
(708) 799-7400

AGENT FOR SERVICE OF LEGAL PROCESS
Community College Insurance Cooperative
17475 Jovanna Drive, 1B
Homewood, IL 60430
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CLAIMS ADMINISTRATOR
Benefit Administrative Systems, L.L.C.
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Homewood, IL 60430
(708) 799-7400