FINDLAY CITY SCHOOLS
EMPLOYEE BENEFIT PLAN
(DENTAL AND VISION)

PLAN DOCUMENT

EBC GROUP NUMBER: F-569

Effective: December 1, 1993

Revised and Restated: August 1, 2008

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SECTION A

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

Certain words in this Plan have precise meanings and will be capitalized and defined in the Definition section or where used in the text, so that you will pay special attention to them.

The Schedule of Coverage is meant only as a summary of benefits. For more details about the benefits, check the Table of Contents and refer to the specific section in the booklet for complete terms and conditions.

The Plan Sponsor has established the Plan for the benefit of eligible employees and their eligible dependents, on the terms and conditions described herein. The Plan Sponsor's purpose in establishing the Plan is to help to offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain medical expenses. The Plan Document is maintained by the Plan Sponsor and may be inspected at any time during normal working hours by any Plan Member.

General Plan Information

Name of Plan:	Findlay City Schools Employee Benefit Plan
Plan Sponsor:	Findlay City Schools 1219 West Main Cross Findlay, OH 45840 Phone Number 419-425-8204
Plan Administrator: (Named Fiduciary)	Findlay City Schools 1219 West Main Cross Findlay, OH 45840 Phone Number 419-425-8204
Plan Sponsor ID No. (EIN):	34-6400447
Fiscal Year:	December 1 through November 30
EBC Group Number:	F-569

Type of Administration:	Self-funded Welfare Plan Dental Expense Benefit Vision Welfare Plan
Sources and Methods of Contributions to the Plan:	The Employer and the Employee share in the cost of the Plan. The Employer's contribution is made from his general assets and the Employee's contribution is made from payroll deductions. The Employer will provide a schedule of the applicable premiums during the initial enrollment, during open enrollment periods, on the Plan's annual renewal date and upon request.
Claims Administrator:	Employee Benefit Consultants, Inc. 215 Stanford Parkway, PO Box 928 Findlay, OH 45840 Phone Number 800-558-7798
Agent for Legal Services:	Findlay City Schools 1219 West Main Cross Findlay, OH 45840 Phone Number 419-425-8204

SECTION B
SCHEDULE OF COVERAGE

NOTE: THIS IS ONLY A SUMMARY, SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO EXCLUSIONS AND LIMITATIONS.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

DENTAL BENEFITS

Calendar Year Deductible	
Individual	$25
Family	$50
Payment Percentages	
Class I Services – Diagnostic and Preventive Care (1)	100%
Class II Services - Basic Services	80%
Class III Services - Major Services	50%
Class IV Services – Orthodontics (2)	60%
Maximum Benefit Payment Amounts	
Per Calendar Year for Class I, II & III Services - Combined	$2,500
Per Lifetime for Class IV Services	$ 850

(1) Class I Services are ***NOT*** subject to the Calendar Year Deductible.
(2) Orthodontic Services are ***LIMITED*** to Dependent children less than 19 years of age.

VISION BENEFITS

Deductible	None
Payment Percentages	100%
Maximum Benefit Payment Amounts	
Examination – once every 12 months	$25
Frames – once every 24 months *	$20
Lenses - Maximum Payable per pair every 12 months	
Single Vision Lenses	$30
Bifocals Lenses	$40
Trifocal Lenses	$60
Lenticular Lenses	$100
Contact Lenses (soft, hard or gas permeable) **	
Medically Necessary Contact Lenses	$160
Cosmetic Contact Lenses	$80

* The frame allowance may be applied toward the cost of lenses, except for contact lenses.

** Contact lenses are not limited to one pair per 12 months, only to the Maximum Payable specified above. Contact lenses are further limited to either Medically Necessary Contact Lenses or Cosmetic Contact Lenses (not both). Benefits for Contact Lenses are payable in lieu of those payable for conventional lenses and frames.

DEFINITIONS OF GENERAL TERMS

When used and capitalized in this document, these terms have the following definitions. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Plan Document for that information.**

CALENDAR YEAR means the period from January 1 through the following December 31.

CONTACT LENSES means ophthalmic corrective lenses ground as prescribed by an Ophthalmologist or Optometrist to be fitted directly to the patient's eye and which meet the Prescription Standards and Tolerances of the American Optometric Association.

CO-PAYMENT PERCENTAGE means any percentage of a bill that is the Plan Member's responsibility to pay after the Plan has paid.

COSMETIC PROCEDURE means a procedure performed solely for the improvement of a Plan Member's appearance rather than for the improvement or restoration of bodily function.

COURSE OF DENTAL TREATMENT means a planned program for the treatment of a dental condition which:

1. May be done by one or more Dentists;
2. Is diagnosed by the attending Dentist by an oral examination; and
3. Begins on the date a Dentist first treats the condition.

COURSE OF ORTHODONTIC TREATMENT means the period that begins when the first orthodontic appliance is installed on the eligible Plan Member and ends when the last orthodontic appliance is removed, provided that successive courses of orthodontic treatment will be considered as one Course of Orthodontic Treatment unless the succeeding course begins more than two years after the end of the preceding Course of Orthodontic Treatment.

COVERED EXPENSES are charges for services that are covered under the Plan. Some charges, although eligible, may be subject to Deductible and Co-payment Percentage provisions where applicable and, therefore, are the Plan Member's responsibility to pay. Charges for non-covered expenses are also the Plan Member's responsibility.

CREDITABLE COVERAGE means the period of time that an individual has been covered by any of the following medical programs:

1. This Plan;
2. Another group health plan;
3. Non-group or individual health insurance coverage issued by a state regulated insurer (including Blue Cross type plans) or an HMO;
4. Medicare (Part A or Part B);
5. Medicaid;
6. Title 10 U.S.C. Chapter 55;
7. American Indian Health Care Programs;
8. A state health benefits risk pool;
9. The Federal Employees Health Plan;
10. A "public health plan" including any plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;
11. The Peace Corp Health Program;
12. A State Children’s Health Insurance Program (S-CHIP).

DEDUCTIBLE means the amount of Covered Expenses payable by the Plan Member each Calendar Year before benefits are paid by the Plan. The family Deductible is the amount contributed toward the Deductible by two or more family members; provided, the amount contributed toward the family Deductible by any one family member cannot be more than the individual Deductible amount.

DENTAL HYGIENIST means a duly licensed Dental Hygienist who works under the supervision of a Dentist.

DENTALLY NECESSARY means dental care services, supplies or treatment that are required to treat the Plan Member's condition or Injury. The Plan will determine whether a service or supply is Dentally Necessary based on the review process and generally accepted dental practice. The service or supply must be:

1. Consistent with and appropriate for the treatment or diagnosis of the Plan Member's symptoms, disease, defect or Injury.

2. Of proven value or usefulness, likely to yield additional information, and not redundant when performed with other procedures.

3. The most appropriate and cost-effective level of service or supply which can safely be provided to the Plan Member.

4. Not primarily for the convenience of the Plan Member's family or the Dentist.

5. Appropriate with regard to standards of generally accepted dental practice.

The fact that a Dentist has prescribed, ordered, recommended or approved a treatment, service, or supply does ***NOT*** in itself make it eligible for payment.

DENTIST means a duly licensed Dentist or Physician who is acting within the scope of his/her license.

DEPENDENT includes only an Employee's:

1. Lawful spouse, and who is not legally separated from the Employee; and

2. Unmarried children to the end of the Calendar Year in which the child reaches 25 years of age, who resides with the Employee, and who is fully dependent upon the Employee for a majority of his/her support within the meaning of the Internal Revenue Code;

3. Unmarried children age 25 or older and who are incapable of self-sustaining employment because of a developmental disability or physical disability and are chiefly dependent upon the Employee for support and maintenance. Proof of such incapacity must be furnished within 31 days of the children reaching the limiting age and thereafter upon request, but not more frequently than annually after the two year period following the child's attainment of the limiting age.

   "Developmental disability" means substantial handicap which results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder.

   "Physical disability" means a physical impairment that substantially limits one or more major life activities such as hearing; breathing; mobility (ability to move); learning; or receptive (understanding) and expressive language. Physical disabilities include but are not limited to: blindness/visual impairment; cancer; diabetes; head injury; heart disease; and mobility impairments. An individual with a minor, non-chronic condition of short duration, such as a sprain, broken limb, or the flu, is not considered disabled.

The term children includes the following:

1. A biological child;

2. An adopted child, including a child placed for adoption. Placement for adoption occurs when an Employee, in anticipation of adopting a child, assumes and retains legal obligation for the total or partial support of that child. Adoptive placement ceases when or if legal obligation ceases;

3. A stepchild;

4. Any child for whom the Employee has obtained legal guardianship and who resides with the Employee in a regular parent-child relationship and is dependent upon the Employee for support and maintenance;

5. Any child for whom coverage is required by a Qualified Medical Child Support Order or by an administrative process established under state law.

6. A foster child if:

   a. Living in a regular parent-child relationship with the expectation that the Employee will continue to rear the child into adulthood;

   b. At the time of enrollment, or at the time a foster child relationship is established, whichever occurs last, the Employee applies for coverage for such child and submits evidence of a bona fide foster child relationship, identifying the foster child by name and setting forth all relevant aspects of the relationship;

   c. The Plan accepts the foster child as a participant through a separate written document identifying the foster child by name and specifically recognizing the foster child relationship; and

   d. At the time a claim is Incurred, the foster child relationship, as identified by the Employee, continues to exist.

   Children placed in a home by a welfare agency, which retains control of, and provides maintenance of, the children, are not eligible participants.

At any time, the Plan may require proof that a spouse or child qualifies or continues to qualify as a Dependent as defined by the Plan.

No person may be covered under this Plan as both an Employee and as a Dependent of an Employee, or as a Dependent of more than one Employee. The term Dependent does not include any person serving in the armed forces of any country.

EBC means Employee Benefit Consultants, Inc.

EFFECTIVE DATE means the date on which a person's coverage under this Plan begins.

EMPLOYEE means an Employee of the Employer who is regularly scheduled to actively perform the principle duties of his/her occupation a minimum of 20 hours per week, and who is enrolled and eligible for coverage under the Plan.

Part-time, seasonal, temporary and retired employees are not eligible for coverage under the Plan.

EMPLOYER means Findlay City Schools.

EXPERIMENTAL/INVESTIGATIONAL/INVESTIGATIVE means a drug, device, medical treatment or procedure that meets any of the following:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or

3. Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

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

IMMEDIATE FAMILY means the Plan Member's spouse, children, brothers, sisters, grandparents, or the parents of the Plan Member or his/her spouse.

INCURRED means the day and time of day Covered Expenses are provided. It does not include a date on which a Plan Member contracts for future delivery of supplies or services.

NOTE: For Dental Benefits, a Covered Expense is considered to be Incurred on the date the service or supply is furnished with the following exceptions:

1. For an appliance or its modifications: on the date the master impression is made;

2. For a crown, bridge, inlay or onlay restoration: on the date the teeth are prepared; and

3. For root canal therapy: on the date the pulp chamber is opened.

INJURY means a condition caused by accidental means which results in damage to the Plan Member's body from an external force and independently of all other causes and which is ***NOT*** related to occupation or employment. Chewing accidents are ***NOT*** considered Injuries.

LIFETIME wherever used in the Plan in reference to benefit maximums and limitations, means while covered under the Plan. Under no circumstances does **"Lifetime"** mean during the lifetime of the Plan Member.

MASTER PLAN DOCUMENT means the Plan Document detailing the provisions of the Plan.

MEDICAID means the medical benefits provided by Title XIX of the Social Security Act, as amended.

MEDICARE means the medical benefits provided by Title XVIII of the Social Security Act, as amended.

OPTHALMOLOGIST means a licensed Doctor of Medicine or Osteopathy who is legally qualified to practice medicine, including providing the diagnosis, the treatment and the prescription of medications and lenses related to conditions of the eye.

OPTICIAN means an individual who makes or deals in eyeglasses, prescribed by an Ophthalmologist or Optometrist to cure or correct defects in the eyes, and grinds the

lenses or has them ground according to prescription, fits them in a frame and adjusts the frame to the fit the patient's face.

OPTOMETRIST means an individual who is legally licensed to practice optometry as defined by the laws of the state in which the services are rendered.

PAYMENT PERCENTAGE means the amount payable by the Plan for Covered Expenses after satisfaction of the Deductible amount, if applicable. The Payment Percentage is shown in the Schedule of Coverage.

PERIODONTICS means the treatment of abnormal conditions of the tissues surrounding the teeth.

PHYSICIAN means a legally licensed doctor of medicine and Surgery, doctor of osteopathy, or doctor of dental Surgery. A Physician shall not include the Plan Member or any member of his/her Immediate Family.

PLAN means the Plan of benefits offered by the Employer according to the provisions of the Master Plan Document.

PLAN MEMBER means an Employee or Dependent, as defined in the Master Plan Document, who is covered by the Plan.

PROTECTED HEALTH INFORMATION (PHI) means health information that is created or received by a Covered Entity, or Employer, and relates to:

1. A person's past, present or future physical or mental health;
2. Provision of health care to that person; or
3. Past, present or future payment for that person's health care.

To be considered Protected Health Information the information must be "individually identifiable health information" which means that in addition to the above requirements, the health information must identify the individual or a reasonable basis must exist to believe that an individual can be identified using the information. Protected Health Information covers information in any form (electronic, oral or written).

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) means a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Plan Member or eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address of the Plan Member and the name and mailing address of each such Alternate Recipient covered by the order;

2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

3. The period of coverage to which the order pertains; and

4. The name of this Plan.

In addition, a National Medical Support Notice (NMSN) shall be deemed a QMCSO if it:

1. Contains the information set forth below;

    a. Name of an issuing state agency;

    b. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Plan Member) or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate recipient(s);

    c. Identity of an underlying child support order;

2. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;

3. Informs the Plan Administrator that, if a group health plan has multiple options and the Plan Member is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and

4. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated Dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Plan Members, except to the extent necessary to meet the requirements of a state law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

SCHEDULE OF COVERAGE means the Schedule at the beginning of the Master Plan Document, or as later amended, which specifies the level of benefits provided by the Plan.

SOUND NATURAL TEETH means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

SUMMARY HEALTH INFORMATION may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ) AND/OR MYOFASCIAL PAIN DYSFUNCTION (MPD) means jaw joint conditions including craniomandibular disorders; and all other conditions of the joint linking the jaw bone, skull; and the complex of muscles, nerves and other tissues related to that joint.

TREATMENT PLAN means a written report prepared by a Dentist, which shows the proposed treatment for the Plan Member's dental disease, defect, or Injury. A Treatment Plan shows all necessary procedures, the series of visits, and the charges for the treatment.

USUAL, CUSTOMARY AND REASONABLE FEE means a charge for a given service by a provider to the majority of his clients, but such charge must be one which is within the range of fees charged by the majority of providers of similar training and experience, for that service within a specific, limited geographic or socioeconomic area as determined by the Plan. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or expertise.

The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross-section of a level of expenses.

The Usual, Customary and Reasonable Fee for surgical procedures mean Covered Expenses for the services of a Physician for performing an operation.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

EMPLOYEE ELIGIBILITY DATE

For new Employees, coverage becomes available on the date of hire. **NOTE:** The Employee must actually begin work for the Employer in order to become eligible for coverage.

The above requirement regarding length of employment shall be waived in any instance where a Plan Member is merely changing from Dependent status to Employee status, or vice versa. In these instances, coverage shall continue without interruption.

NOTE: If an Employee does not enroll for coverage under this Plan when he/she is initially eligible to enroll for coverage, he/she may enroll for coverage under this Plan at a later date subject to the Special Enrollment Period or the Open Enrollment Period, as explained elsewhere in the Plan Document.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

Coverage becomes effective on the date the eligibility requirement is satisfied provided the Employee enrolls for coverage within 31 days following his/her date of hire. **NOTE:** If the Employee is not actively at work on his/her date of hire, coverage will not become effective until the Employee's first day of work for the Employer and provided the Employee enrolls for coverage within 31 days following his/her first day of active work.

DEPENDENT ELIGIBILITY DATE

An Employee becomes eligible for Dependent coverage on the later of:

1. The date the Employee becomes covered;
2. The date the Employee acquires an eligible Dependent; or
3. The date the Employee is required, by a Qualified Medical Child Support Order or by an administrative process established under state law, to provide Dependent coverage.

DEPENDENT EFFECTIVE DATE OF COVERAGE

Dependent coverage required by a Qualified Medical Child Support Order (QMCSO) or by an administrative process established under state law will become effective on the latest of the following dates:

1. The date the Employee becomes eligible for Dependent coverage;

2. The date specified by the QMCSO;

3. The date the Employee's coverage becomes effective;

4. The date the person becomes a Dependent.

All other Dependent coverage will become effective on the same day as the Employee upon whom they are dependent, provided the Employee has enrolled for family coverage.

Individuals who become an eligible Dependent of an Employee after the Employee's Effective Date of coverage will be eligible for coverage as explained under the CHANGE IN STATUS provision.

NOTE: If an Employee does not enroll his/her eligible Dependents for coverage under this Plan when they are initially eligible to be enrolled for coverage, the Employee may enroll his/her eligible Dependents for coverage under this Plan at a later date subject to the Special Enrollment Period or the Open Enrollment Period, as explained elsewhere in the Plan Document.

CHANGE IN STATUS

If an Employee is covered for single coverage and wants to change to family coverage because of a change in marital status, he/she must request family coverage within 31 days of the date of marriage, in order for coverage to become effective on the date of the marriage.

Should an Employee's marital status change due to divorce or legal separation, notification of that change must be given to the Employer within 60 days of the date of that change.

Employees who have single coverage may request a change to family coverage to add an eligible Dependent child, by submitting a new enrollment form within 31 days of acquiring the child as an eligible Dependent, in which case the child's coverage would become effective on the date he/she became an eligible Dependent of the Employee.

Employees who have family coverage, may add an additional eligible Dependent, by submitting a new enrollment form within 31 days of acquiring the individual as an eligible Dependent, in which case the individual's coverage would become effective on the date he/she became an eligible Dependent of the Employee. Newborns are automatically covered under the plan if family coverage is already in effect on the date of birth.

Any request for coverage after the 31 days will be subject to the Special Enrollment Period provision or the Open Enrollment Period.

SPECIAL ENROLLMENT PERIOD

If an Employee declines coverage for himself/herself or for his/her Dependents (including the Employee's spouse) because of other health coverage, the Employee will be able to enroll himself/herself and/or his/her Dependents in this Plan at a future date, provided that the Employee requests coverage within 31 days after other coverage ends. Coverage becomes effective on the first of the month following the date of enrollment.

This special enrollment period ***ONLY*** applies to individuals whose prior Creditable Coverage:

1. Was under COBRA and they exhausted that COBRA coverage; or

2. Was not under COBRA and they lost that prior Creditable Coverage due to:

   a. events that are similar to COBRA qualifying events (including, but not limited to loss of eligibility as a result of legal separation, divorce, death, termination or reduction in hours of employment or a child aging out under other parent's coverage);

   b. the plan no longer offering any benefits to a class of similarly situated individuals (e.g. part-time employees);

   c. the cessation of the employer contributions for that prior Creditable Coverage (actual termination of other coverage is not required);

   d. moving out of an HMO's service area; or

   e. reaching a lifetime limit for all benefits.

   However, loss of eligibility does **NOT** include a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

An Employee must make a request for Special Enrollment within 31 days of the loss of the previous Creditable Coverage and must supply the Plan with a Certificate of Creditable Coverage under the other group health plan.

In addition, if an Employee, who declined coverage in this Plan for himself/herself or for his/her Dependents, acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee will be allowed to enroll for coverage for himself/herself and/or his/her spouse and/or the new child, provided that the Employee requests coverage within 31 days after the marriage, birth, adoption or placement for adoption.

EXAMPLES:

1. In the case of marriage, an Employee who had previously declined coverage could become covered, with or without his/her spouse, under the Special Enrollment Period provision. Coverage becomes effective on the first of the month following the date of enrollment.

2. In the case of birth or adoption, an Employee and/or his/her spouse, who had previously declined coverage in this Plan could become covered under the Special Enrollment Period provision. Coverage becomes effective on the child's date of birth, adoption or placement for adoption.

NOTE: During a Special Enrollment, the Employee may add a new Dependent under the Employee's current plan option or the Employee may switch to another option, **if applicable** (e.g., an Employee who is covered under this Plan may switch to an HMO plan offered by the Employer or change from one option under this Plan to another option under this Plan).

OPEN ENROLLMENT PERIOD

If an Employee declines coverage for himself/herself or for his/her Dependents (including the Employee's spouse) at the time such individuals are eligible for coverage, the Employee will be able to enroll himself/herself and/or his/her eligible Dependents during any Open Enrollment Period. Each year, during the month of **August**, the Employer will offer an Open Enrollment Period to eligible individuals (Employees and Dependents) who are not already covered under this Plan. Any individual enrolling for coverage under this Plan during an Open Enrollment Period (other than a new Employee who has not yet satisfied his/her eligibility-waiting period) will have coverage effective on the first of the following month.

NOTE: An Employee's eligible Dependent(s) may ***NOT*** be covered under this Plan unless the Employee is also covered. (This limitation does not apply to COBRA coverage.)

TERMINATION OF INDIVIDUAL COVERAGE

Coverage under this Plan shall terminate at midnight on the earliest of the following:

1. The date the Plan is terminated for all Plan Members;

2. The date a required contribution, if any, is due but the Plan Member fails to make the contribution;

3. With regard to a specific benefit, on the date the benefit is terminated or deleted from the Plan;

4. The date the Plan Member requests termination of any or all coverage under the Plan. The request for termination must be in writing and all forms required by the Plan Administrator must be completed;

5. The date the Plan Member ceases to be eligible for coverage under the Plan, except as specified below;

6. For Employees:

   a. If an Employee is on a leave of absence that qualifies under an applicable state family and medical leave act and/or the Family and Medical Leave Act of 1993 (FMLA), or as later amended, coverage will terminate at the end of the leave if the Employee does not return to work at that time;

      NOTE: If the leave of absence is due to the Employee's own Sickness/Injury, the leave may not exceed the maximum period specified by the applicable state and/or federal leave act or the time period specified in (b) below, whichever is longer. If the leave is due to any other qualified reason the leave may not exceed the maximum period specified by FMLA or equivalent state act.

   b. If an Employee does not work the required number of hours to be considered an eligible Employee for any reason other than those specifically listed above, (i.e.; Injury or sickness that does not qualify under the FMLA; voluntary or involuntary termination of employment; or reduction in hours), coverage will terminate at the end of the calendar day on which the Employee ceases full-time active work;

7. For Dependents:

   a. Coverage will terminate on the same day as coverage terminates for the Employee under whom they are covered;

   b. Coverage will terminate on the day the individual no longer meets the Plan's Definition of an eligible Dependent;

   c. Coverage will terminate on the date as specified in the Qualified Medical Child Support Order or by an administrative process established under state law if eligibility for Dependent coverage is solely based on this order.

NOTE: An Employee shall not terminate or cause the termination of his/her Dependents' (spouse or children) coverage due to the filing of divorce, annulment, dissolution of marriage or legal separation unless a court determines that the Employee is no longer responsible for providing coverage for such Dependents.

NOTE: Coverage shall be canceled automatically, without notice, if a Plan Member:

1. Attempts, through deceit, to obtain benefits that otherwise would not be provided by this Plan; or

2. Attempts to obtain benefits for someone not entitled to benefits under this Plan.

This Plan shall at all times be in compliance with the applicable state family medical leave act and/or the Family and Medical Leave Act (FMLA) of 1993, or as later amended, provided the Employer is required to comply with such acts. The FMLA will run concurrently with any extension of coverage specified above.

SECTION E

CONTINUATION OF COVERAGE UPON INDIVIDUAL TERMINATION (COBRA)

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Members and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. The following paragraphs generally explain COBRA coverage, when it may become available and what a Qualified Beneficiary needs to do to protect his or her right to receive it.

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a Qualified Beneficiary.

COBRA CONTINUATION COVERAGE? COBRA coverage is a temporary extension of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event". Specific Qualifying Events are listed below in the section entitled "What is a Qualifying Event".

COBRA (and the description of COBRA coverage contained in the plan document and summary plan description "SPD") applies only to the group health plan benefits offered under the Plan (the Dental and Vision) and not to any other benefits offered by the Employer (such as life insurance, disability income, or accidental death or dismemberment benefits).

COBRA coverage is the same coverage that the Plan gives to other Plan Members under the Plan who are not receiving COBRA coverage. Each Qualified Beneficiary who elects COBRA will have the same rights under the Plan as other Plan Members covered under the component or components of the Plan elected by the Qualified Beneficiary, including Open Enrollment and Special Enrollment rights.

In considering whether or not to take COBRA, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. The election of continuation coverage may help you to not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not obtain continuation coverage for the maximum time available to you. Finally, 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 30 days after your group

health coverage ends because of the Qualifying Event. You will also have the same special enrollment right at the end of continuation coverage if you obtained continuation coverage for the maximum time available to you.

WHO IS A QUALIFIED BENEFICIARY? In general, a Qualified Beneficiary is:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the spouse of a covered Employee, or a Dependent child of a covered Employee.

2. A child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is considered to be a Qualified Beneficiary provided that, if the covered Employee is a Qualified Beneficiary, the covered Employee has elected COBRA coverage for himself/herself. The child's COBRA coverage begins when the child is enrolled in the Plan, including when enrolled through a Special Enrollment or an Open Enrollment.

3. A child who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO), received by the Employer during the covered Employee's period of employment with the Employer, is entitled to the same rights to elect COBRA as an eligible Dependent child of the covered Employee.

If however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer coverage constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his/her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractors, owners or corporate directors).

WHAT IS A QUALIFYING EVENT? If you are a covered **Employee** you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of either of the following Qualifying Events:

1. your hours of employment are reduced; or

2. your employment ends for any reason other than your gross misconduct.

If you are a covered **spouse** of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of any of the following Qualifying Events:

1. your spouse dies;

2. your spouse's hours of employment are reduced;

3. your spouse's employment ends for any reason other than his/her gross misconduct;

4. your spouse becomes entitled to Medicare; or

5. you become divorced or legally separated from your spouse. Also, if your spouse (the Employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

If you are a covered **Dependent child** of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of any of the following Qualifying Events:

1. the Employee dies;

2. the Employee's hours of employment are reduced;

3. the Employee's employment ends for any reason other than his/her gross misconduct;

4. the Employee becomes entitled to Medicare;

5. the parent's of the Dependent child become divorced or legally separated; or

6. you stop being eligible for coverage under the Plan as a Dependent child.

If an Employee takes FMLA leave and does not return to work at the end of the leave, the Employee (and the Employee's spouse and Dependent children, if any) will be entitled to elect COBRA if:

1. they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and

2. they will lose Plan coverage within 18 months because of the Employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.)

If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the Employee and Dependents will be entitled to COBRA coverage even if they failed to pay the Employee portion of the contribution for coverage under the Plan during the FMLA leave.

WHEN IS COBRA COVERAGE AVAILABLE? When the Qualifying Event is the end of employment, reduction of hours of employment, or death of the Employee, the Plan will offer COBRA coverage to Qualified Beneficiaries. You need not notify the Employer of any of these three Qualifying Events. An Election Form will automatically be provided.

For the other Qualifying Events (divorce or legal separation of the Employee and spouse, or a Dependent child losing eligibility for coverage as a Dependent child), a COBRA Election Form will be sent to you only if you notify the Employer in writing within 60 days after the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the Qualifying Event.

You must follow the procedures specified in the section below entitled "Notice Procedures". If these procedures are not followed or if the notice is not provided in writing to the Employer during the 60-day notice period, **YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.** You may obtain a copy of the Notice Procedures from the Employer.

WHAT IS THE ELECTION PERIOD AND HOW LONG MUST IT LAST? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of his/her right to elect COBRA continuation coverage.

HOW MAY COBRA COVERAGE BE ELECTED? To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the Employer.

Mail, hand-deliver or fax the completed Election Form to:

Insurance Enrollment Coordinator
Findlay City Schools
1219 West Main Cross
Findlay, OH 45840
Telephone number 419-425-8204
Fax number 419-425-8203

The Election Form must be completed in writing and mailed, hand-delivered or faxed to the individual at the address/fax number specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; electronic communications, including e-mail messages; and faxed communications (unless they are on a proper Election Form).

If mailed, your Election Form must be postmarked (and if hand-delivered or faxed, your Election Form must be received by the individual at the address/fax number specified above) no later than 60 days after the date of the COBRA election notice provided to

you at the time of your Qualifying Event. **IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

Each Qualified Beneficiary (including a child who is born to, adopted by or placed for adoption with a COBRA covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage. Covered Employees and spouses (if the spouse is a Qualified Beneficiary) may elect COBRA on behalf of all of the Qualified Beneficiaries, and parents may elect COBRA on behalf of their children.

Qualified Beneficiaries may be enrolled in one or more group health components of the Plan at the time of a Qualifying Event. If a Qualified Beneficiary is entitled to a COBRA election as the result of a Qualifying Event, he/she may elect COBRA under any or all of the group health components of the Plan under which he/she was covered on the day before the Qualifying Event.

When you complete the Election Form you must notify the Employer if any Qualified Beneficiary has become enrolled under Medicare (Part A, Part B, or both) and, if so, the date of Medicare enrollment. If you become enrolled under Medicare (or first learn that you are enrolled under Medicare) after submitting the Election Form, immediately notify the Employer of the date of your Medicare enrollment at the address specified for delivery of the Election Form.

Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are enrolled under Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he/she becomes enrolled under Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied). See the section entitled "When may a Qualified Beneficiary's COBRA continuation coverage be terminated?".

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer.

If you reject COBRA before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

WHAT ARE THE MAXIMUM COVERAGE PERIODS FOR COBRA CONTINUATION COVERAGE? The maximum coverage periods are based on the type of Qualifying Event and the status of the Qualified Beneficiary, as shown below:

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

2. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

   a. 36 months after the date the covered Employee becomes enrolled in the Medicare program. For example, if a covered Employee becomes enrolled under Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan for his spouse and Dependent children who lost coverage as a result of his termination can last up to 36 months after the date the Employee became enrolled under Medicare, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). This COBRA coverage period is available only if the covered Employee becomes enrolled under Medicare within 18 months **BEFORE** the termination or reduction of hours; or

   b. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

3. In the case of any other Qualifying Event than those described above, the maximum coverage period ends 36 months after the Qualifying Event.

In the case of a Qualified Beneficiary who is a child born to, adopted by or placed for adoption with a COBRA covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born, adopted or placed for adoption.

UNDER WHAT CIRCUMSTANCE CAN THE MAXIMUM COVERAGE PERIOD BE EXPANDED? If the Qualifying Event that resulted in your COBRA election was the covered Employee's termination of employment or reduction in hours, an extension of the maximum coverage period may be available if a Qualified Beneficiary is disabled or a second Qualifying Event occurs. You must notify the Employer of a disability or a second qualifying event in order to extend the period of COBRA coverage. **FAILURE TO PROVIDE NOTICE OF A DISABILITY OR SECOND QUALIFYING EVENT WILL ELIMINATE THE RIGHT TO EXTEND THE PERIOD OF COBRA COVERAGE.**

1. **Disability extension of COBRA coverage**. If a Qualified Beneficiary is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, all of the Qualified Beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for Qualified Beneficiaries who are receiving COBRA coverage because of a Qualifying Event that was the covered Employee's termination of employment or reduction in hours. The disability must have started at some time before the 61st day after the covered Employee's termination of employment or reduction of hours (this includes disabilities

that began prior to the Employee's termination of employment or reduction of hours). The disability must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each Qualified Beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the Employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

a. the date of the Social Security Administration's disability determination;

b. the date of the covered Employee's termination of employment or reduction of hours; or

c. the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered Employee's termination of employment or reduction of hours.

You must provide the Social Security Administration's determination notice within 18 months after the covered Employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

You must follow the procedures specified in the section below entitled "Notice Procedures". If these procedures are not followed or if the notice is not provided in writing to the Employer during the 60-day notice period and within 18 months after the covered Employee's termination of employment or reduction of hours, **THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.** You may obtain a copy of the Notice Procedures from the Employer.

2. **Second Qualifying Event extension of COBRA coverage.** An extension of coverage will be available to spouses and Dependent children who are receiving COBRA coverage if a Second Qualifying Event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered Employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a Second Qualifying Event occurs is 36 months. Such Second Qualifying Events may include the death of a covered Employee, divorce or legal separation from the covered Employee, or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Plan. These events can be a Second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred. (This extension is not available under the Plan when a covered Employee becomes enrolled under Medicare.)

   This extension due to a Second Qualifying Event is available only if you notify the Employer in writing of the Second Qualifying Event within 60 days after the later of:

a. the date of the Second Qualifying Event; or

b. the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of the Second Qualifying Event (if it had occurred while the Qualified Beneficiary was still covered under the Plan).

In providing this notice, you must follow the procedures specified in the section below entitled "Notice Procedures". If these procedures are not followed or if the notice is not provided in writing to the Employer during the 60-day notice period, **THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.** You may obtain a copy of the Notice Procedures from the Employer.

WHAT IS THE COST OF COBRA CONTINUATION COVERAGE? The amount a Qualified Beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health Plan for coverage of a similarly situated Plan Member who is not receiving COBRA coverage (including both Employer and Employee contributions). The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

WHAT ARE THE COBRA CONTINUATION COVERAGE PAYMENT PROCEDURES? If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the designated address/fax number, if hand-delivered or faxed.) See the section above entitled "How may COBRA coverage be elected?"

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make the first payment. (For example, your employment terminates on September 30, and you lose coverage on September 30. You elect COBRA coverage on November 15. Your initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of your COBRA election.) You are responsible for making sure that the amount of your first premium payment is correct. You may contact the Employer using the contact information provided under the section entitled "How may COBRA coverage be elected?" to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, YOU WILL LOSE ALL COBRA RIGHTS UNDER THE PLAN.

After you make your first payment for COBRA coverage you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due

for each month for each Qualified Beneficiary will be disclosed in the election notice provided to you at the time of your Qualifying Event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. Although periodic notices of payments due for these coverage periods will be sent – it is your responsibility to pay your COBRA premiums on time.

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly 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 monthly payment before the end of the grace period for that month, YOU WILL LOSE ALL RIGHTS TO COBRA COVERAGE UNDER THE PLAN.

All COBRA premiums must be paid by check or money order. CASH WILL NOT BE ACCEPTED.

Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to:

Insurance Enrollment Coordinator
Findlay City Schools
1219 West Main Cross
Findlay, OH 45840
Telephone Number 419-425-8204
Fax Number 419-425-8203

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

WHEN MAY A QUALIFIED BENEFICIARY'S COBRA CONTINUATION COVERAGE BE TERMINATED? COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can terminate before the end of the maximum coverage period for several reasons, which are described below.

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

1. timely payment is not made to the Plan with respect to the Qualified Beneficiary. **NOTE:** Invalid payments (i.e., checks returned due to insufficient funds) will result in retroactive termination of coverage.

2. the Employer ceases to provide any group health plan (including successor plans) to any Employee.

3. a Qualified Beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Qualified Beneficiary have been exhausted or satisfied).

4. a Qualified Beneficiary becomes enrolled under Medicare benefits (Part A, Part B, or both) after electing COBRA.

5. during a disability extension period, the disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled.

You must notify the Employer in writing within 30 days if, after electing COBRA, a Qualified Beneficiary becomes enrolled under Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Qualified Beneficiary have been exhausted or satisfied). COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare enrollment or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any pre-existing condition exclusions for a pre-existing condition of the Qualified Beneficiary). The Employer will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare enrollment or other group health plan coverage.

If a disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Employer of that fact within 30 days after the Social Security Administration's determination. If the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all Qualified Beneficiaries will terminate (retroactively, if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled. The Employer will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice that the disabled Qualified Beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Under what circumstances can the maximum coverage period be expanded?")

You must follow the procedures specified below under the section entitled "Notice Procedures for Notice of Other Coverage, Medicare Enrollment, or Cessation of Disability". You may obtain a copy of the Notice Procedures from the Employer.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a Plan Member not receiving COBRA coverage (such as fraud).

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

DOES A QUALIFIED BENEFICIARY HAVE A DUTY TO KEEP THE PLAN INFORMED OF ADDRESS CHANGES? In order to protect your family's rights, you must keep the Employer and the Plan's Claims Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Employer and the Plan's Claims Administrator.

QUESTIONS? If you have questions about your COBRA continuation coverage, you should contact the Employer or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

CONTACTS: You may obtain information about COBRA coverage on request from:

1. **The Employer (Plan Administrator):**

   Insurance Enrollment Coordinator
   Findlay City Schools
   1219 West Main Cross
   Findlay, OH 45840
   Telephone Number 419-425-8204
   Fax Number 419-425-8203

2. **COBRA Administrator:**

   COBRA continuation coverage for the Plan is administered by:

   Infinisource, Inc.
   15 E. Washington Street
   P. O. Box 889
   Coldwater, MI 49036-0889
   Telephone number 800-320-3040

The contact information for the Plan may change from time to time. The information will be included in the Plan's most recent SPD (if you are not sure whether this is the Plan's most recent SPD, you may request the most recent one from the Employer).

NOTICE PROCEDURES

Notice Of Qualifying Event. The deadline for providing this notice of Qualifying Event is 60 days after the later of:

1. the date of the Qualifying Event (i.e., a divorce or legal separation or a child's loss of Dependent status); and

2. the date on which the covered spouse or Dependent child would lose coverage under the terms of the Plan as a result of the Qualifying Event.

If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and you are notifying the Employer that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, you must provide notice within 60 days of the divorce or legal separation in accordance with these Notice Procedures for Notice of Qualifying Event. You must provide evidence satisfactory to the Employer that your coverage was reduced or eliminated in anticipation of the divorce or legal separation, if the Employer requests such evidence.

You must mail, hand-deliver or fax this notice to:

Insurance Enrollment Coordinator
Findlay City Schools
1219 West Main Cross
Findlay, OH 45840
Telephone Number 419-425-8204
Fax Number 419-425-8203

Your notice must be in writing and must be mailed, hand-delivered or faxed. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand-delivered or faxed, your notice must be received by the individual at the address specified above no later than the deadline described above.

You may obtain a copy of the Notice Procedures from the Employer.

Your notice must contain the following information:

1. the name of the Employer;

2. the name and address of the Employee or former Employee who is or was covered under the Plan;

3. the name(s) and address(es) of all Qualified Beneficiary(ies) who lost coverage due to the Qualifying Event (divorce, legal separation, or child's loss of Dependent status);

4. the Qualifying Event (divorce, legal separation, or child's loss of Dependent status);

5. the date of the divorce, legal separation, or child's loss of Dependent status; and

6. the signature, name, and contact information of the individual sending the notice.

If you are notifying the Employer of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

Incomplete Notice of a Qualifying Event. If you provide written notice but it does not contain all of the information and documentation required by these Notice Procedures for Notice of a Qualifying Event, such notice will nevertheless be considered timely **if all of the following conditions are met**:

1. the notice is mailed, hand-delivered or faxed to the individual at the address/fax number specified above;
2. the notice is provided by the deadline described above;
3. from the written notice provided, the Employer is able to identify the covered Employee and Qualified Beneficiary(ies), the Qualifying Event (the divorce, legal separation, or child's loss of Dependent status), and the date on which the Qualifying Event occurred; and
4. the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's notice requirements within 15 business days after a written or oral request from the Employer for more information (or, if later, by the deadline for the Notice of a Qualifying Event as described above).

IF ANY OF THESE CONDITIONS IS NOT MET, THE INCOMPLETE NOTICE WILL BE REJECTED AND COBRA WILL NOT BE AVAILABLE. If all of these conditions are met, the Employer will accept the notice as timely.

Who may provide a Notice of Qualifying Event? The covered Employee (i.e., the Employee or former Employee who is or was covered under the Plan), a Qualified Beneficiary with respect to the Qualifying Event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all Qualified Beneficiaries who lost coverage due to the Qualifying Event described in the notice.

Additional evidence of the date of a child's loss of Dependent status may be required. If your notice is regarding a child's loss of Dependent status, you must, if the Employer requests it, provide documentation of the date of the Qualifying Event that is satisfactory to the Employer (for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution). This will allow the Employer to determine if you gave timely notice of the Qualifying Event and were consequently entitled to elect COBRA. If you do not provide satisfactory evidence, within 15 business days after a written request from the Employer, that the child ceased to be Dependent on the date specified in your Notice of a Qualifying Event, his/her COBRA coverage may be terminated (retroactively, if applicable) as of the date that COBRA coverage would have started. The Employer will require repayment to the Plan of all benefits paid after the termination date.

Notice Of Disability. The deadline for providing this notice is 60 days after the latest of:

1. the date of the Social Security Administration's disability determination;

2. the date of the covered Employee's termination of employment or reduction of hours; or

3. the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of termination of employment or reduction of hours. Your Notice of Disability must also be provided within 18 months after the Covered Employee's termination of employment or reduction of hours.

You must mail, hand-deliver or fax this notice to:

Insurance Enrollment Coordinator
Findlay City Schools
1219 West Main Cross
Findlay, OH 45840
Telephone Number 419-425-8204
Fax Number 419-425-8203

Your notice must be in writing and must be mailed, hand-delivered or faxed. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand-delivered or faxed, your notice must be received by the individual at the address/fax number specified above no later than the deadline described above.

You may obtain a copy of the Notice Procedures from the Employer.

Your notice must contain the following information:

1. the name of the Employer;

2. the name and address of the Employee or former Employee who is or was covered under the Plan;

3. the initial Qualifying Event that started your COBRA coverage (the covered Employee's termination of employment or reduction of hours);

4. the date that the covered Employee's termination of employment or reduction of hours occurred;

5. the name(s) and address(es) of all Qualified Beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;

6. the name and address of the disabled Qualified Beneficiary;

7. the date that the Qualified Beneficiary became disabled;

8. the date that the Social Security Administration made its determination of disability and the date the Social Security Administration subsequently

determined that the Qualified Beneficiary is no longer disabled (if applicable); and

9. the signature, name, and contact information of the individual sending the notice.

Your Notice of Disability must include a copy of the Social Security Administration's determination of disability.

Incomplete Notice of Disability. If you provide written notice but it does not contain all of the information and documentation required by these Notice Procedures for Notice of Disability, such notice will nevertheless be considered timely **if all of the following conditions are met**:

1. the notice is mailed, hand-delivered or faxed to the individual at the address/fax number specified above;

2. the notice is provided by the deadline described above;

3. from the written notice provided, the Employer is able to determine that the notice relates to a Qualified Beneficiary's disability;

4. from the written notice provided, the Employer is able to identify the covered Employee and Qualified Beneficiary(ies), and the date on which the covered Employee's termination of employment or reduction of hours occurred; and

5. the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Disability) within 15 business days after a written or oral request from the Employer for more information (or, if later, by the deadline for the Notice of Disability as described above).

IF ANY OF THESE CONDITIONS IS NOT MET, THE INCOMPLETE NOTICE WILL BE REJECTED AND COBRA WILL NOT BE EXTENDED. If all of these conditions are met, the Plan will accept the notice as timely.

Who may provide a Notice of Disability? The covered Employee (i.e., the Employee or former Employee who is or was covered under the Plan), a Qualified Beneficiary who lost coverage due to the covered Employee's termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all Qualified Beneficiaries who may be entitled to an extension of the maximum coverage period due to the disability reported in the notice.

Notice Of A Second Qualifying Event. The deadline for providing this notice is 60 days after the later of:

1. the date of the Second Qualifying Event (i.e., a divorce or legal separation, the covered Employee's death, or a child's loss of Dependent status); or

2. the date on which the covered spouse or Dependent child would lose coverage under the terms of the Plan as a result of the Second Qualifying Event (if this event had occurred while the Qualified Beneficiary was still covered under the Plan).

You must mail, hand-deliver or fax this notice to:

Insurance Enrollment Coordinator
Findlay City Schools
1219 West Main Cross
Findlay, OH 45840
Telephone Number 419-425-8204
Fax Number 419-425-8203

Your notice must be in writing and must be mailed, hand-delivered or faxed. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand-delivered or faxed, your notice must be received by the individual at the address/fax number specified above no later than the deadline described above.

You may obtain a copy of the Notice Procedures from the Employer.

Your notice must contain the following information:

1. the name of the Employer;

2. the name and address of the Employee or former Employee who is or was covered under the Plan;

3. the initial Qualifying Event that started your COBRA coverage (the covered Employee's termination of employment or reduction of hours);

4. the date that the covered Employee's termination of employment or reduction of hours occurred;

5. the name(s) and address(es) of all Qualified Beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;

6. the Second Qualifying Event (a divorce or legal separation, the covered Employee's death, or a child's loss of Dependent status);

7. the date that the divorce or legal separation, the covered Employee's death, or a child's loss of Dependent status occurred; and

8. the signature, name, and contact information of the individual sending the notice.

If you are notifying the Employer of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

Incomplete Notice of a Second Qualifying Event. If you provide written notice, but it does not contain all of the information and documentation required by these Notice Procedures for Notice of a Second Qualifying Event, such notice will nevertheless be considered timely **if all of the following conditions are met**:

1. the notice is mailed, hand-delivered or faxed to the individual at the address/fax number specified above;

2. the notice is provided by the deadline described above;

3. from the written notice provided, the Employer is able to identify the covered Employee and Qualified Beneficiary(ies), the first Qualifying Event (the Employee's termination of employment or reduction of hours), the date the first Qualifying Event occurred, the Second Qualifying Event (the divorce, legal separation, Employee's death, or child's loss of Dependent status), and the date on which the Second Qualifying Event occurred; and

4. the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of a Second Qualifying Event) within 15 business days after a written or oral request from the Employer for more information (or, if later, by the deadline for the Notice of a Second Qualifying Event as described above).

IF ANY OF THESE CONDITIONS IS NOT MET, THE INCOMPLETE NOTICE WILL BE REJECTED AND COBRA WILL NOT BE EXTENDED. If all of these conditions are met, the Plan will accept the notice as timely.

Who may provide a Notice of a Second Qualifying Event? The covered Employee (i.e., the Employee or former Employee who is or was covered under the Plan), a Qualified Beneficiary who lost coverage due to the covered Employee's termination of employment or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all Qualified Beneficiaries who may be entitled to an extension of the maximum coverage period due to the Second Qualifying Event described in the notice.

Additional evidence of the date of a child's loss of Dependent status may be required. If your notice is regarding a child's loss of Dependent status, you must, if the Employer requests it, provide documentation of the date of the Qualifying Event that is satisfactory to the Employer (for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution). This will allow the Employer to determine if you gave timely notice of the Second Qualifying Event and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written request

from the Employer that the child ceased to be Dependent on the date specified in your Notice of Second Qualifying Event, his/her COBRA coverage may be terminated (retroactively, if applicable) as of the date that COBRA coverage would have ended without an extension due to loss of Dependent status. The Employer will require repayment to the Plan of all benefits paid after the termination date.

Additional evidence of the date of the covered Employee's death may be required. If your notice is regarding the death of the covered Employee, you must, if the Employer requests it, provide documentation of the date of death that is satisfactory to the Employer (for example, a death certificate or published obituary). This will allow the Employer to determine if you gave timely notice of the Second Qualifying Event and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written request from the Employer that the date of death was the date specified in your Notice of Second Qualifying Event, the COBRA coverage of all Qualified Beneficiaries receiving an extension of COBRA coverage as a result of the covered Employee's death may be terminated (retroactively, if applicable) as of the date that COBRA coverage would have ended without an extension due to the covered Employee's death. The Employer will require repayment to the Plan of all benefits paid after the termination date.

NOTICE OF OTHER COVERAGE, MEDICARE ENROLLMENT OR CESSATION OF DISABILITY

Notice of Other Coverage. If you are providing a Notice of Other Coverage (a notice that a Qualified Beneficiary has become covered, after electing COBRA, under other group health plan coverage), the deadline for this notice is 30 days after the other coverage becomes effective or, if later, 30 days after exhaustion or satisfaction of any pre-existing condition exclusions for a pre-existing condition of the Qualified Beneficiary.

Notice of Medicare Enrollment. If you are providing a Notice of Medicare Enrollment (a notice that a Qualified Beneficiary has become enrolled, after electing COBRA, under Medicare Part A, Part B, or both), the deadline for this notice is 30 days after the beginning of Medicare enrollment (as shown on the Medicare card).

Notice of Cessation of Disability. If you are providing a Notice of Cessation of Disability (a notice that a disabled Qualified Beneficiary whose disability resulted in an extended coverage period is determined by the Social Security Administration to no longer be disabled), the deadline for this notice is 30 days after the date of the Social Security Administration's determination.

You must provide these notices to:

> **Insurance Enrollment Coordinator**
> **Findlay City Schools**
> **1219 West Main Cross**
> **Findlay, OH 45840**
> **Telephone Number 419-425-8204**
> **Fax Number 419-425-8203**

Your notice must be provided no later than the deadline described above.

You may obtain a copy of the Notice Procedures from the Employer.

Your notice must contain the following information:

1. the name of the Employer;

2. the name and address of the Employee or former Employee who is or was covered under the Plan;

3. the initial Qualifying Event that started your COBRA coverage;

4. the date that the initial Qualifying Event occurred;

5. If you are providing a Notice of Other Coverage, your notice must include the name and address of the Qualified Beneficiary who obtained other coverage, the date that the other coverage became effective (and, if there were any pre-existing condition exclusions applicable to the Qualified Beneficiary, the date that these were exhausted or satisfied), and evidence of the effective date of the other coverage (such as a copy of the insurance card or application for coverage);

6. If you are providing a Notice of Medicare Enrollment, your notice must include the name and address of the Qualified Beneficiary who became enrolled under Medicare, the date that Medicare enrollment occurred, and a copy of the Medicare card showing the date of Medicare enrollment;

7. If you are providing a Notice of Cessation of Disability, your notice must include the name and address of the disabled Qualified Beneficiary, the date of the Social Security Administration's determination that he/she is no longer disabled, and a copy of the Social Security Administration's determination; and

8. the signature, name, and contact information of the individual sending the notice.

The covered Employee (i.e., the Employee or former Employee who is or was covered under the Plan), a Qualified Beneficiary with respect to the Qualifying Event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the other coverage, Medicare enrollment, or cessation of disability reported in the notice.

If a Qualified Beneficiary first becomes covered by other group health plan coverage after electing COBRA, that Qualified Beneficiary's COBRA coverage will terminate (retroactively, if applicable) as described above in the section entitled "When may a Qualified Beneficiary's COBRA continuation coverage be terminated?" regardless of whether or when a Notice of Other Coverage is provided.

If a Qualified Beneficiary first becomes enrolled under Medicare Part A, Part B, or both after electing COBRA, that Qualified Beneficiary's COBRA coverage will terminate (retroactively, if applicable) as described above in the section entitled "When May a

Qualified Beneficiary's COBRA Continuation Coverage Be Terminated?" regardless of whether or when a Notice of Medicare enrollment is provided.

If a disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, COBRA coverage for all Qualified Beneficiaries whose COBRA coverage is extended due to the disability will terminate (retroactively, if applicable) as described above in the section entitled "When May a Qualified Beneficiary's COBRA Continuation Coverage Be Terminated?" regardless of whether or when a Notice of Cessation of Disability is provided.

UNIFORMED SERVICES CONTINUATION AND REINSTATEMENT PROVISION

Continuation

A Plan Member who:

1. Is employed by the Employer;

2. Is determined by the Employer to be eligible for benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA);

3. Is absent from his/her position of employment with the Employer by reason of service in the uniformed services; and

4. Would otherwise have his/her coverage under the Plan terminated,

may elect to continue the coverage under the Plan that the Plan Member and his/her eligible covered Dependents had prior to such absence for a period not to exceed the lesser of:

1. The twenty four month period beginning on the date on which the Plan Member's absence begins; or

2. The day after the date on which the Plan Member fails to apply for or return to a position of employment as specified by the Employer.

Reinstatement

Upon re-employment, coverage under the Plan will be reinstated for a person who was absent from his/her position of employment with the Employer by reason of service in the uniformed services, as well as for his/her eligible Dependents who were covered Plan Members under the Plan at the time the absence began provided that:

1. The person was a covered Plan Member under the Plan until the time his/her absence from employment with the Employer commenced by reason of service in the uniformed services;

2. The person makes application for re-employment within the time limit specified by the Employer; and

3. At the time the person makes application for re-employment, he/she is entitled to benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

In such instances, an exclusion of the Plan, Pre-existing Condition Limitation, or waiting period will not be applied, if that exclusion of the Plan, Pre-existing Condition Limitation,

or waiting period would not have been applied had coverage not been terminated as a result of service in the uniformed services. This also applies to any eligible Dependent of the covered person who becomes covered by the Plan as a result of such reinstatement of coverage.

An exclusion or waiting period may be imposed for any Injury or Sickness determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

OHIO STATE UNIFORMED SERVICES CONTINUATION AND REINSTATEMENT PROVISION

This provision applies to an eligible person who, at the time a reservist is called or ordered to active duty, if covered under this Plan and is either of the following:

1. An Employee who is reservist called or ordered to active duty;
2. The spouse or Dependent child of an Employee described above.

Any eligible person may continue their coverage under this Plan for a period of eighteen months after the date on which coverage would otherwise have terminated because the reservist is called or ordered to active duty.

An eligible person may extend the eighteen-month period of continuation of coverage to a thirty-six-month period of continuation of coverage, if any of the following occurs during the eighteen-month period:

1. The death of the reservist;
2. The divorce or separation of a reservist from the reservist’s spouse;
3. The cessation of dependency of a child according to the terms of the Plan.

The thirty-six-month period of continuation of coverage begins on the date on which the coverage would otherwise have terminated because the reservist was called or ordered to active duty.

The benefits provided under this provision shall be the same as those offered to any other Plan Member covered under the Plan who has not been called or ordered to active duty.

The Employer shall notify each Employee of this provision at the time of employment. At the time the reservist is called or ordered to active duty, the Employer shall notify the reservist and his/her covered Dependents of the requirements for this continuation of coverage.

An eligible person must request continuation of coverage under this provision and pay the required contribution to the Employer within 31-days of the date his/her coverage would otherwise have terminated. If the Employer notifies the eligible person of the right of continuation of coverage after the date on which the eligible person’s coverage would

otherwise terminate, the written election and payment of the required contribution must be received by the Employer no later than 31-days after the date of notification.

An eligible person shall pay to the Employer, on a monthly basis and in advance, the amount of contribution required by the Employer. The amount shall not exceed 102% of the group rate for the coverage being continued under the Plan on the due date of each payment. A reservist called or ordered to active duty for less than 31-days shall not be required to pay more than the eligible person's contribution, if any, for the coverage.

GENERAL LIMITATIONS AND EXCLUSIONS

The Plan will not provide benefits for the following, ***UNLESS*** specifically stated otherwise in this Plan:

1. **Claim Forms.** Expenses for completion of claim forms or for preparation of medical reports; for missed appointments or for computer, internet, and telephone consultations.

2. **Criminal Activities.** Charges Incurred for treatment of an Injury or Sickness sustained while the Plan Member is participating in an illegal occupation; commission of, or an attempt to commit, a felony; or voluntary participation in a riot, insurrection or civil disobedience.

3. **Employer Facilities** - Services and supplies provided through a medical department, clinic or other facility provided by or maintained by the Plan Member's employer, or a medical clinic or similar facility for which services or supplies are or should be available without charge to the Plan Member.

4. **Excess of Maximum Benefit.** Charges in excess of any maximum benefit stated in the Plan.

5. **Excess of Usual, Customary and Reasonable Fee.** For expenses made which are in excess of the Usual, Customary and Reasonable Fee.

6. **Experimental.** Charges for services and supplies, which are Experimental/Investigational/Investigative.

7. **Government.** Expenses Incurred by a Plan Member that may be covered or reimbursed by any agency or public program funded by any national, state, provincial, county, or local government or any other political subdivision, instrumentality or agency thereof, except Medicare and Medicaid.

8. **Government Operated Facilities** - Services furnished to the Plan Member in any veteran's Hospital, military Hospital, institution or facility operated by the United States Government, by any state government, by any agency or instrumentality of such government, or any foreign government agency, for which the Plan Member has no legal obligation to pay for services rendered or expenses Incurred, except for care or service furnished by a tax supported state Hospital for treatment of Mental/Nervous Disorders.

9. **Immediate Family.** Services performed by a person who is a member of the Plan Member's Immediate Family or who resides in the Plan Member's home.

10. **No Legal Obligation.** Expenses for which the Plan Member has no legal obligation to pay or for an expense which would not have been made if the person did not have coverage under this Plan.

11. **Not Recommended.** For any service or supply which is not recommended or approved by a Physician.

12. **Prescription Drugs.** Drugs or medications, including prescriptions, other than injection of antibiotics and application of desensitizing medication by the attending Dentist.

13. **Prior to Effective Date.** Charges Incurred prior to a Plan Member's Effective Date under the Plan.

    In the case of prosthetic devices and crowns, charges will not be covered if the impressions were taken before the date coverage commenced, even though the prosthetic device or crown is not installed until after the Plan Member's Effective Date of Coverage.

14. **Unlicensed Providers.** Any services rendered by unlicensed/uncertified providers, if a license or certificate is required by law where the services are rendered, or services that are outside the scope of the license of a provider.

15. **War/Military Service.** Services or supplies Incurred due to an Injury or Sickness caused by war or an act of war (whether declared or undeclared), nuclear explosion or nuclear accident or major nuclear disaster, or service in the armed forces of any country. An act of terrorism will not be considered an act of war, declared or undeclared.

16. **Worker's Compensation.** Expenses due to a work-related Injury or Sickness sustained while doing anything pertaining to any occupation or employment for remuneration or profit for which all or part of the expense is payable by workers' compensation or similar law.

Notwithstanding the above exclusions, the Plan will not deny benefits for Covered Expenses for treatment of an Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

DEDUCTIBLE PROVISIONS

The Deductible amount can only be satisfied by Dental Covered Expenses. The Deductible applies to all Covered Expenses ***UNLESS*** specifically stated otherwise.

The family Deductible is the amount contributed toward the Deductible by two or more family members; provided, the amount contributed toward the family Deductible by any one family member cannot be more than the individual Deductible amount.

Once a family has collectively satisfied the family Deductible amount as shown in the Schedule of Coverage during a Calendar Year, no further Deductibles will be applied to Covered Expenses for other members of the family for the remainder of the Calendar Year.

Covered Expenses Incurred during October, November or December, which are used to satisfy all or part of the individual and family Deductibles will also be used to satisfy the individual and family Deductibles for the next Calendar Year. Any Deductible carryover will be based on the date a Covered Expense is Incurred.

LIFETIME MAXIMUM PAYMENT AMOUNT

The Plan will pay benefits, per individual, up to the Lifetime Maximum Payment Amount shown in the Schedule of Coverage. This is a Lifetime maximum even though a break in coverage under the Plan may have occurred. Refer to the Schedule of Coverage to determine which charges paid by the Plan are included in this amount.

DENTAL BENEFITS

Voluntary Pre-Determination of Benefit

Before receiving dental services for a Course of Dental Treatment of more than $200.00, the Plan Member or his/her Dentist may request a pre-determination of benefits by sending the treatment plan to EBC. EBC will estimate what benefits are payable. Where the Plan gives prior written estimate for a treatment, service or supply, benefits will be paid if the Plan Member's coverage is in force at the time such treatment, service or supply is provided and if the Treatment Plan has not changed.

If the Dentist submits a pre-determination claim form and then changes the procedures originally indicated, the Claims Administrator will adjust the payments accordingly. If the Dentist makes a major change in treatment, a revised form may be submitted.

Alternate Procedures

In determining the amount of benefits payable, the Plan Administrator will consider alternate procedures, services, or courses of treatment that may be performed for the Plan Member's dental condition to achieve the desired results. If the Plan Sponsor determines that alternative procedures, services, or course of treatment could be performed to correct a dental condition, benefits will be provided for the least costly procedure(s) that would produce a professionally satisfactory result.

Covered Dental Expenses

The Plan will pay benefits for Covered Expenses Incurred by a Plan Member for dental services, only when performed by a Dentist or a Dental Hygienist, or other dental provider working under the direction and supervision of the Dentist. The payment is subject to the General Limitations and Exclusions and all other provisions of the Plan. The Payment Percentages and maximums are shown in the Schedule of Coverage.

Class I Services –Preventive and Diagnostic Services

1. Preventive:

   a. Routine oral examinations, limited to 2 exams per 12-month period.

   b. Prophylaxis (scaling and cleaning of teeth) limited to 2 treatments per 12-month period.

   c. Topical fluoride treatments - limited twice in any 12-month period.

d. Space maintainers that replace prematurely lost teeth - limited to Plan Members less than 19 years of age. The allowance also includes any adjustments made during the first six months after installation.

e. Emergency Palliative Treatment and other non-routine, unscheduled visits.

2. Diagnostic - Bitewing films - limited to 2 sets of x-rays per 12-month period.

Class II Services – Basic Services

1. Full mouth series or a panoramic x-ray - limited to once in any 36 consecutive month period and other x-rays required to treat a dental condition.

2. Tests and laboratory examinations including bacteriologic cultures, pulp vitality, and diagnostic cast (study models).

3. Oral Surgery, including necessary pre-operative treatment during a hospital confinement and customary post-operative treatment furnished in connection with oral surgery.

   a. Extraction of one or more teeth, except when done in connection with Class B services; and

   b. Alveoplasty (surgical preparation of ridge for dentures) and tooth replantation.

4. Restorative - Procedures to eliminate oral disease:

   Direct filling procedures - including amalgam, silicate, acrylic, synthetic porcelain, composite filling restorations and gold restorations of diseased or broken teeth.

5. Endodontics including, but not limited to, root canal therapy, pulp capping and pulpotomy.

6. Injection of antibiotic drugs and application of desensitizing medication by the attending Dentist or Physician.

7. Repair or recementation of crowns, inlays, onlays, bridgework or dentures, and relining or rebasing of dentures.

8. Periodontics – the treatment of gums and supportive structures of the teeth.

9. Apicoectomy.

10. Sealants – limited to the unrestored permanent molars of Plan Members less than 19 years of age and to one treatment in any 36-month period.

11. Surgical and non-surgical treatment (including appliance therapy) for treatment of Temporomandibular Joint Dysfunction (TMJ).

12. General anesthesia and its administration when administered in connection with any Class II Service.

Class III Services – Major Dental Repair Services

1. Inlays, onlays, or crown restorations to restore diseased or fractured teeth.

2. Prosthodontics:

   a. Initial insertion of fixed or removable (partial dentures) bridges (including bridge abutments and pontics).

   b. Full dentures. The allowance includes all adjustments by the Dentist furnishing the denture in the first 6 months after installation. Temporary dentures older than one year are considered to be a permanent appliance.

3. Replacement of an existing removable partial or complete denture or fixed partial denture by a new removable or fixed partial denture, or the addition of teeth to an existing removable partial denture to a fixed partial denture, but only if such denture was installed at least five years prior to its replacement.

4. General anesthesia and its administration when administered in connection with Major Dental Repair Services.

5. Implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants.

Class IV Services – Orthodontic Services.

NOTE: The following orthodontic services will be payable for Dependent children less than 19 years of age only:

1. Preliminary studies including x-rays, diagnostic casts and the treatment plan and the first month of active treatment, including all active treatment and retention appliance.

2. Active treatment per month after the first month.

3. Fixed or cemented appliances – only one appliance per Plan Member for tooth guidance and/or to control harmful habits.

4. Charges which began as an ongoing Course of Orthodontic Treatment prior to the Plan Member's Effective Date of Coverage, shall be considered by this Plan as of the Plan Member's Effective Date of Coverage (i.e., monthly adjustments to appliances).

Related oral examinations, surgery, extractions and other covered services are included and are payable under Class IV Services.

Dental Exclusions

In addition to the General Limitations and Exclusions of the Plan, no benefits are available for:

1. Services, supplies, or equipment which:

   a. Are rendered by other than a Dentist (DDS or DMD), or a Dental Hygienist or x-ray technician under the supervision of a Dentist; or

   b. Are furnished in connection with or as a result of a non-covered service.

2. Services, supplies, or equipment furnished after the date the Plan Member's coverage ends, except for:

   a. Prosthetic devices which were ordered and fitted before, and completed within 60 days after, the date the Plan Member's coverage ends; and

   b. Procedures, other than prosthetics, which were begun before, and completed in one visit within 31 days after, the date the Plan Member's coverage ends.

3. Services, supplies, or equipment that are not Dentally Necessary.

4. Dental services rendered or furnished in connection with elective plans of treatment. To the extent that they are available, the Plan will provide benefits for the suitable plan of treatment carrying the lesser fee.

5. Dental services for congenital malformations, or primarily for cosmetic or esthetic purposes. This exclusion applies to existing teeth, not to congenitally missing teeth.

6. Charges for:

   a. Any duplicate appliance or device;

   b. The replacement of a lost, stolen, or missing prosthetic device;

   c. The replacement or repair of an orthodontic appliance;

   d. Appliances intended for sport or home use, such as athletic mouth guards;

7. Replacement charges of a bridge, crown or denture within 5 years after the date it was originally installed, unless:

   a. Such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or

   b. The bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an Injury received while a person is an eligible Plan Member.

8. Charges for:

   a. Oral hygiene counseling and dietary instruction;

   b. Plaque control programs and other educational programs;

   c. Sealants, except as specifically stated otherwise;

   d. Periodontal splinting of teeth except for provisional intracoronal stabilization of mobile teeth.

9. Any dental services for which coverage is provided under the terms of the Employer sponsored Medical Plan. Removal, repair or replacement of any fillings, crowns, bridgework or any other dental work performed for medical reasons.

10. Precision or semi-precision attachments (except when they represent the sole method of completing a Course of Treatment), precision or semi-precision partials, overdentures, customized prosthetics or treatment partials, **except** as specified otherwise in the Plan.

11. Personalization or characterization of dentures.

12. Appliances, restorations, or procedures needed to adjust vertical dimension or to restore occlusion, except as an integral part of comprehensive orthodontic treatment.

13. Local anesthesia or partial anesthesia (analgesia).

14. Services which are considered experimental or which are not approved by the American Dental Association.

VISION BENEFIT

Charges Incurred for Routine vision services are payable and **LIMITED** as shown in the Schedule of Coverage.

Contact lenses are considered Medically Necessary only if one of the following conditions apply:

1. Following cataract Surgery;
2. Visual acuity is not correctable to 20/70 in either eye with other lenses, but can be corrected to at least 20/70 in one eye with Contact Lenses;
3. Anisometropia; or
4. Keratoconus.

All other Contact Lenses are considered Cosmetic.

Vision Exclusions

Procedures requiring hospitalization, Surgery, x-rays or laboratory work are **NOT** covered under the vision benefit, but may be covered under the medical benefit portion of this Plan. In addition to the General Limitations and Exclusions of the Plan, vision benefits do **NOT** cover the following:

1. Services or supplies not listed as Covered Expenses in the Schedule of Coverage.
2. Eye examinations required by an employer as a condition of employment, or which the employer is required to provide by virtue of a labor agreement or those required by a governmental body.
3. Medical or surgical treatment of the eye.
4. Orthoptics (a technique or eye exercise designed to correct a vision defect) and vision training or subnormal vision aids.
5. Treatment of aniseikonia (a vision defect in which the image of an object is seen by the other eye).
6. Examination not provided by, and lenses not prescribed by, an ophthalmologist (M.D.) or a licensed optometrist.
7. Tints – Charges for tints other than number 1 or number 2 (including sunglasses) or a tint with photosensitive or anti-reflective properties.

8. Safety glasses.

9. Prescription or non-prescription sunglasses.

10. Lenses that can be obtained without prescription.

11. Any lenses or frames during the same period during which an allowance for contact lenses is received.

12. Replacement of lost, stolen or broken lenses or frames, except at the normal intervals when services are otherwise available.

13. Charges Incurred after the Plan Member's termination from the Plan.

CARE PROVIDED BY THE UNITED STATES GOVERNMENT

The Plan will reimburse for care rendered by the Veterans Administration for non-service connected disabilities, on the same basis as these services are otherwise covered by the Plan.

The Plan will reimburse for care rendered by the United States to military retirees and dependents who are covered by this Plan on an inpatient basis through a facility of the uniformed services, on the same basis as these services are otherwise covered under the Plan.

COORDINATION OF BENEFITS

The Plan contains a non-profit provision coordinating it with other Plans under which an individual is covered so that total benefits available will not exceed 100% of the allowable expense for the services. If the Plan is secondary, the amount by which the secondary plan's benefits have been reduced shall be used to pay the stated percentage of Allowable Expenses, not otherwise paid by the primary plan.

An "Allowable Expense" is any necessary, reasonable and customary expense at least a portion of which is covered by one of the plans covering the Plan Member for whom a 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 shall be considered both an Allowable Expense and a benefit paid.

"Claim Determination Period" means the time during any one benefit year when a person is covered and incurs charges for services or supplies covered under this Plan and one other plan.

As each claim is submitted, each plan determines its liability and pays or provides benefits based upon Allowable Expenses incurred during the Claim Determination Period. However, that determination is subject to adjustment as later Allowable Expenses are incurred during the same Claim Determination Period.

"Plan" means any plan providing health benefits or health services including but not limited to:

1. Group, blanket or franchise insurance coverage;

2. Group practices and other group pre-payment coverage;

3. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and

4. Any coverage under governmental programs, such as Medicare, and any coverage required or provided by any statute, such as no-fault auto insurance.

"Plan" shall not include:

1. School accident type coverage;

2. Hospital indemnity coverage; or

3. Individual insurance coverage.

EFFECT ON BENEFITS

When a claim is made, the primary plan pays its benefits without regard to any other plan. The secondary plan adjusts its benefits so that the total benefits available will not exceed the Allowable Expense. No plan pays more than it would without the coordinating provision.

A plan without a coordinating provision is always the primary plan. If all plans have such a provision:

1. The plan covering the individual directly (active employee), rather than as an employee's dependent, is primary and others are secondary. If the other plan contains a secondary only provision whereby such plan considers their plan to be in excess of other available benefits, the Employer’s Plan will coordinate to consider benefits payable on a secondary basis. A description of the benefit coverage from the individual’s plan will be requested. Benefits payable under this Employer’s Plan will then be calculated based on a reduction of what the payment would have been under the individual’s plan in the absence of the existence of this Employer’s Plan. If the benefits are not furnished from the individual’s plan, then this Plan will assume that the benefits under the individual’s plan are at the same level as the Employer’s Plan and payment will be based on what the payment would have been in the absence of any secondary only provision.

2. If a child is covered under both parents' plans, the plan covering the parent whose birth date, excluding the year of birth, occurs earlier in the Calendar Year shall be the primary plan, and the plan covering the parent whose birth date is later in the Calendar Year shall be the secondary plan.

   If both parents have the same birth date, then the plan covering the parent the longest will be primary and the plan covering the parent for the shorter period of time will be secondary.

3. If a claim is made for a dependent child whose parents are separated or divorced, the following order of benefit determination shall apply:

a. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or

b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the step-parent, and the benefits of a plan which covers that child as a dependent of the step-parent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Notwithstanding (a) and (b) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

4. If (1), (2) or (3) do not apply, the plan covering the individual the longest is primary. However, if an individual is laid-off, retired or covered as a COBRA qualified beneficiary and is covered by two plans, the plan covering the individual as an active employee will be primary and the plan covering the individual as a laid-off or retired employee or as a COBRA qualified beneficiary will be secondary. This provision also applies to coverage for dependents of any employee who is laid-off, retired or covered under COBRA.

   For determining the benefits for a retiree who is also covered as a Dependent of an active Employee, the plan that covers the person as a non-dependent (for example, as an employee) pays before the plan that covers the person as a dependent. This rule is referred to as the non-dependent/dependent rule, which supersedes the active/inactive rule.

   NOTE: If the employee is retired and also a Medicare Beneficiary, a different rule shall be used. In this situation the plan that covers the individual as a dependent of an active worker pays first, Medicare pays second and then the plan that covers the individual as other than a retired employee pays last.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any other plan, the plan may without the consent of or notice to any persons release to, or obtain from, any insurance company or other organization or

person any information with respect to any person which it deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan information as may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payments which should have been made under the Plan in accordance with this provision have been made under any other plan, the Plan shall have the right, exercisable alone and at its sole discretion, to pay any organizations 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 for covered services, the Plan shall be fully discharged from liability.

SECTION L

MEDICARE SELECTION PROVISION

If the Employer has **less** than 20 Employees in the current Calendar Year, Medicare coverage is primary (and this Plan will be secondary) for active Employees age 65 or older and their Dependents 65 or older. This Plan will reduce payment by the amount paid or payable by Medicare.

If the Employer had 20 or **more** Employees in the current or preceding Calendar Year, Federal law requires that Medicare coverage be secondary to this Plan. The Plan Member has the option of rejecting this Plan thereby retaining Medicare as his/her primary coverage. If the Plan Member chooses Medicare as primary, the Employer can not provide any supplemental coverage. If the Plan Member rejects coverage under this Plan that choice must be made in writing to the Employer.

Federal law also mandates which plan is primary in the case of certain persons who are totally disabled or have end stage renal disease.

NOTE: This Plan will determine the primary and secondary payment of claims based on the current rules and regulations set forth by Medicare.

SECTION M

GENERAL PROVISIONS

The Plan and The Master Plan Document

The Plan Sponsor has filed the Master Plan Document in the office of the Human Resource Department, which can be inspected at any time during normal working hours by any Plan Member.

The Plan is maintained pursuant to a collective bargaining agreement, a copy of which may be obtained by Plan Members upon written request and is available for examination in the office of the Human Resource Department at any time during normal working hours by any Plan Member.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Administrator.

Plan Administrator

The Plan Administrator as used herein shall be the person or firm responsible for the day to day functions and management of the Plan. The Plan Administrator is the Employer.

The construction and interpretation of the Plan are vested with the Plan Administrator, in its absolute discretion, including, without limitation, the determination of benefits, eligibility and interpretation of Plan provisions. The Plan Administrator will endeavor to act, whether by general rules or by particular decisions, so as to treat all persons in similar circumstances without discrimination. All such decisions, determinations and interpretations shall be final, conclusive and binding upon all parties having an interest in the Plan.

Named Fiduciary

The Named Fiduciary is the Plan Administrator and has the authority to control and manage the operation and administration of the program. A participant under the Plan will not receive Plan benefits unless the Plan Administrator determines that the participant is entitled to such benefits.

Claims Administrator

The Claims Administrator will provide technical services in connection with operation of the coverage and performing other functions.

The Plan Is Not An Employment Contract

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

Exchange Of Information

The Plan will promptly provide to appropriate Federal, state and local law enforcement authorities and to other appropriate health plans:

1. Information indicating a potential violation of civil, criminal, or administrative laws relating to fraud and abuse with respect to health plans.
2. Information requested by Federal, state, or local law enforcement agencies which the agency states is relevant to an investigation, audit, evaluation, or inspection under the Federal Fraud and Abuse Control Program.
3. Information which would assist in the identification of potential violations or assist in the identification of areas requiring investigation, audit, evaluation, or inspection. Such information may include:
   a. Surveys; Quality assurance reviews;
   b. Provider and patient profiles;
   c. Utilization review, and
   d. Other similar analyses.

Alternative Treatment

The Plan Administrator has the right to approve coverage for treatment, procedures or facilities that are not normally covered under the Plan, if the Plan Administrator feels that this alternative treatment, procedure or facility offers a cost-effective method of treating the Plan Member's condition. Such approval in no way obligates the Plan Administrator to approve such coverage in the future, nor does it obligate the Plan Administrator to approve of Alternative Treatment for any other Plan Member. Each case will be decided on its own merits.

Free Choice of Physician

Each Plan Member has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. The Plan Member, together with his Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Qualified Medical Child Support Orders (QMCSO)

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a “Qualified Medical Child Support Order” (“QMCSO”) if such an individual is not already covered by the Plan as an eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

“Alternate Recipient” shall mean any child of a Plan Member who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Plan Member’s eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent and an Alternate Recipient shall have the same status as a Plan Member.

Upon receiving a Medical Child Support Order (Order), the Plan Administrator shall, as soon as administratively possible:

1. Notify the Plan Member and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan’s procedures for determining whether the Order qualifies as a QMCSO; and

2. Make an administrative determination if the Order is a QMCSO and notify the Plan Member and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice (Notice), the Plan Administrator shall:

1. Notify the state agency issuing the Notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

   a. Whether the child is covered under the Plan; and

   b. Either the Effective Date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and

2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

A Plan Member may request at any time a copy of QMCSO procedures from the Plan without charge.

Other Service Plan Contracts

If any Plan Member is covered under more than one Plan, the coverage that would be provided under this Plan in the absence of this provision shall be reduced to the extent necessary so that the sum of such reduced coverage, together with the benefits, if any, that are paid or payable under such other Plan contract for health service shall not exceed the total charges for the health service.

Worker's Compensation Notice

The Plan is not in lieu of, is not in any way subject to, and does not affect any requirement for coverage by worker's compensation insurance.

Erroneous Payment Refund Provision

Covered Expenses are occasionally paid erroneously by the Plan (i.e., paid more than once; incorrectly paid under the Plan's terms, conditions, limitations or exclusions; or conditionally paid pending further review). An Employee, Dependent, or health care service provider receiving such an overpayment or erroneous payment shall, upon discovery or notice thereof, return such payment to the Plan within 30 days of discovery or demand. Neither the Plan nor the Plan Administrator shall have any obligation to make any other payment of the bill prior to refund by the health care provider, Employee or Dependent. A health care provider may not apply an erroneous or duplicate payment to another bill balance or any other Dependent. The Plan Administrator shall have the exclusive right to choose who will repay it for an overpayment or erroneous payment (i.e., including but not limited to the Employee, Dependent, health care service provider or another health benefit plan). If the Plan elects to seek refund from the Employee or Dependent, recovery of the overpaid amount shall, at the Plan Administrator's option, be reimbursed in a lump-sum, time payments or deducted from future claims presented for processing.

Health care service providers accepting payment for services from the Plan, in consideration of such payments, further agree to submit claims for reimbursement in strict accord with their state's health care practice acts, ICD-9, or CPT standards,

Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator.

Any claims not paid in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur a pre-judgment interest rate of 1 ½% per month. The Plan shall be entitled to litigation costs and actual attorney fees in the event it becomes necessary to institute suit to recover duplicate or erroneous payments or payments of improperly billed charges.

Conformity With Applicable Law

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

Clerical Error

Clerical errors, such as inaccurate transcription of premiums, Effective Dates, termination dates, or such as erroneous mailings, shall not change the rights or obligations of any party under the Plan and shall not operate to grant additional benefits to Plan Members.

Fraud

The following actions by any Plan Member, or a Plan Member's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for that Plan Member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Plan Member in the Plan;

2. Attempting to file a claim for a Plan Member for services which were not rendered or drugs or other items that were not provided;

3. Providing false or misleading information in connection with enrollment in the Plan; or

4. Providing any false or misleading information to the Plan.

No Waiver

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves

the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed by each Plan Member.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan. The amount of the Plan Member's contribution will be determined from time to time by the Plan Administrator.

Booklets

The Plan Administrator has issued to each Employee an individual booklet, which summarizes the benefits to which the person is entitled, to whom benefits are payable, and the provisions of the Plan affecting the Plan Members.

Entire Plan

The Plan including any amendments, the Schedule of Coverage, any other applicable schedules, the attached papers, the application of the Employer for any reinsurance policy, and the individual applications, if any, of the Employees and eligible Dependents, constitute the entire description of benefits between the parties and any statement made by the Employer or by any Employee shall not, in any way, change such benefits.

All statements made by the Employer or by a Plan Member shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense of a claim unless they are contained in writing and signed by the Employer or by the Plan Member, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such contest.

Plan Modification and Amendment

The Treasurer of the Employer shall be empowered to amend this Plan or any benefit under this Plan at any time by a written instrument signed by the Treasurer. An increase or decrease in Plan benefits will become effective as of the date specified in the Plan or in an applicable amendment.

The Plan will furnish each Plan Member with a summary of any material reductions in covered services or benefits not later than 60 days after the effective date of such change.

Plan Termination

The Treasurer of the Employer may terminate the Plan at any time. Upon termination, the rights of the Plan Members to benefits are limited to claims Incurred and due up to the date of termination. Any termination of the Plan will be communicated to Plan Members.

Assignment

The Plan Member's benefit payments may not be assigned except by consent of the Company to other than suppliers of medical services.

Automatic Assignment

All medical expense benefits payable under this Plan shall be paid to the medical service provider, unless the claimant furnishes proof of payment of the medical expenses at the time the claim is filed with the Claims Administrator, in which case the benefits shall be paid to the claimant.

Physical Examination

The Plan at its own expense shall have the right and opportunity to examine any Plan Member, whose Injury or Sickness is the basis of a claim, as often as it may reasonably require while a claim is pending.

Disclosure Of Electronic Protected Health Information ("Electronic PHI") To The Plan Sponsor For Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

1. Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;

3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and

4. Report to the Plan any Security Incident of which it becomes aware.

Any terms not otherwise defined shall have the meanings set forth in the Security Standards.

Privacy Standards

1. Disclosure of Summary Health Information to the Plan Sponsor.

   In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

   "Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes.

   In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

   a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

   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 or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

e. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);

f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

i. 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, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    i. The following Employees or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

    Treasurer
    Insurance Enrollment Coordinator

    ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

    iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Document relating to use and disclosure of PHI, the Plan Sponsor shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance

occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor.

   Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan.

4. Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage.

   The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

5. Other Disclosures and Uses of PHI.

   With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

SECTION N

SUBROGATION/RIGHT OF REIMBURSEMENT

As a condition to receiving benefits under this Plan, Plan Member(s), including all Dependents, agree to transfer to the Plan their rights to make claim, sue and recover from any person or business entity any funds paid or payable as a result of personal Injury or reimbursement of Covered Expenses (medical, dental, vision, prescription drugs and/or disability benefits, if applicable), including the billed amount of discounted or capitated services. Alternatively, if an Employee or a Dependent receives any recovery, by way of judgment, settlement or otherwise, from another person or business entity, the Employee or Dependent agrees to reimburse the Plan in full, in first priority, for any Covered Expenses paid by it (including the billed amount of discounted or capitated services). In other words, the Plan shall be first reimbursed fully from any monies received, with the balance, if any, retained by the Plan Member.

The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the settlement or judgment designates the recovery, or a portion thereof, as including Covered Expenses (medical, dental, vision, prescription drugs and/or disability benefits, if applicable), paid by the Plan. A repayment agreement may be required to be signed. However, this clause remains in effect regardless of whether it is actually signed.

The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the Employee, Dependent or guardian receives or is entitled to receive from the third party, any liability or other insurance covering the third party, any first party benefits such as uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault or school insurance coverage which are paid or payable. The Plan may enforce its reimbursement or subrogation rights by requiring the Employee, Dependent or guardian to assert a claim to any of the foregoing coverage to which he/she may be entitled.

An Employee or Dependent, by receipt of benefits under this Plan, agrees to cooperate fully with the Plan and shall provide any information requested by the Plan within five days of request. The Employee or Dependent shall give the Plan or its administrator immediate notice in writing of any personal injury claim or any other claim for reimbursement of Covered Expenses (medical, dental, vision, prescription drugs and/or disability benefits, if applicable), filed with any person or business entity. The Employee or Dependent shall not settle or compromise any claim unless the Plan or its administrator is notified in writing at least thirty days before such settlement or compromise and agrees thereto in writing. Regardless of whether the settlement or judgment includes Covered Expenses, (medical, dental, vision, prescription drugs and/or disability benefits, if applicable), the Plan Member shall immediately repay the amount of any benefits the Plan has paid plus interest at the rate of 1 1/2% per month commencing on the date of the settlement or judgment. An Employee or Dependent who waives, abrogates or impairs the Plan's recovery rights or otherwise fails to comply with the obligations specified herein, relieves the Plan from any obligation to pay past or future benefits or expenses. The Plan may, in its discretion, offset the amount of Covered Expenses related to the subject incident from its obligation to pay any past or future Covered Expenses (medical, dental, vision, prescription drugs and/or disability benefits, if applicable), of the Employee or any Dependent.

The Plan will not pay attorney fees or costs associated with the Employee's or Dependent's claim/lawsuit without prior written authorization. Once the personal injury claim is settled, the Plan will not pay past or future benefits or claims related to that Injury or accident.

CLAIM/APPEAL PROCEDURES

PROOF OF CLAIMS

Written proof of claims for payment of covered expenses must be furnished to the Plan, by the Plan Member or Provider, as the case may be within 90 days after the date such claims are Incurred.

If the claimant is unable to provide written proof of loss, the Plan will not reduce or deny the claim as long as the proof is filed as soon as it is reasonably possible. However, the proof required must be submitted to the Claims Administrator no later than one year from the date of loss, unless the claimant is legally incapable.

A health service shall be considered as Incurred on the date the services or supplies are rendered or received.

PHYSICAL EXAMINATION

The Plan, at its own expense, shall have the right and opportunity to examine any Plan Member whose Injury or Sickness is the basis of any claim, as often as it may reasonably require during the pendency of a claim hereunder.

CLAIM QUESTIONS

All questions regarding claims should be directed to Employee Benefit Consultants, Inc.

CLAIM DENIAL

In the event a claim is denied, the Plan Member will be advised of the following:

1. The reason for the denial;

2. Specific reference to Plan provisions on which the denial was based;

3. Any additional material or information necessary for further review of the claim; and

4. Explanations of the Plan's review procedure.

CLAIM REVIEW

There are two types of Claim Reviews available to Plan Members: Internal Reviews and External Independent Reviews. Plan Members must exhaust the Plan's Internal Review Procedures before requesting an External Independent Review.

INTERNAL REVIEW OF DENIED CLAIMS

If a claim for health care services has been denied, reduced or terminated, the Plan Member may be entitled to an "internal review" of the claim. An internal review may be requested if the denial was for any the reasons listed below:

1. The service is not Medically Necessary;

2. The service is Experimental/Investigative and the Plan Member has a terminal illness;

3. The service is not covered under the terms of the Plan.

An internal review may be requested by the Plan Member, an authorized person, the health care provider or the health care facility. However, a health care provider or health care facility must have the Plan Member's authorization to request an internal review. The request for an internal review must be made to the Claims Administrator within 90 days of the date the claim was denied.

The Plan Member cannot be required to pay for the review. The review will be paid for by the Plan.

1. Denial Because Services are Not Medically Necessary

If a claim has been denied because the service is not Medically Necessary and a request has been made for an internal review, the Plan will use a "clinical peer" for the internal review.

A clinical peer is a Physician when the service being evaluated for medical appropriateness will be provided by a Physician. If the service being evaluated for medical appropriateness would be provided by a provider who is not a Physician, then a clinical peer means a Physician or other provider holding the same license as the provider who will perform the requested service.

The clinical peer will review the Plan Member's medical records and determine if the service is Medically Necessary. If the clinical peer determines that the service is Medically Necessary, the Plan will pay for the service. Any payment by the Plan will be subject to the Plan's Deductibles, Copays and other limitations on payment.

If the clinical peer determines that the service is not Medically Necessary, the Plan will not pay for the service. In that case, the Plan Member has the right to request an External Independent Review, as described below.

2. Denial Because Services are Experimental/Investigative

If a claim has been denied because the service is considered Experimental/Investigative and a request has been made for an internal review, the Plan will use a “clinical peer” for the internal review.

A clinical peer is a Physician when the service being evaluated for medical appropriateness will be provided by a Physician. If the service being evaluated for medical appropriateness would be provided by a provider who is not a Physician, then a clinical peer means a Physician or other provider holding the same license as the provider who will perform the requested service.

The clinical peer will review the Plan Member’s medical records and determine if the service is Experimental/Investigative. If the clinical peer determines that the service is not Experimental/Investigative, the Plan will pay for the service. Any payment by the Plan will be subject to the Plan’s Deductibles, Copays and other limitations on payment.

If the clinical peer determines that the service is Experimental/ Investigative, the Plan will not pay for the service. In that case, the Plan Member has the right to request an External Independent Review, as described below.

3. Denial Because Services are Not Covered

If a claim has been denied because the service is not covered and a request has been made for an internal review, the Plan will again review the claim and advise the Plan Member if the claim will then be allowed or denied based on any additional information supplied by the Plan Member.

If the claim is again denied, the Plan Member may request a review from the Ohio Department of Insurance. This review is available only after the second review by the Plan has been made. The Plan Member may write the Department of Insurance at:

The Ohio Department of Insurance
Consumer Services Division
2100 Stella Court
Columbus, Ohio 43215-1067

The Plan Member may also call the Department of Insurance at 1-800-686-1526.

The Department of Insurance will review the terms of the Plan and the type of health care service the Plan Member has requested. If the Department determines that the service is not a covered expense, the Plan does not have to pay for the service. The determination by the Department is final. An external independent review is not available.

If the Department determines that the service is a covered expense, the Plan may, but is not required to, pay for the service. Any payment by the Plan will be subject to the Plan's Deductibles, Copays and other limitations on payment.

The Department of Insurance also will inform the Plan Member if it cannot make a determination because it involves the resolution of a medical issue. In that case, the Plan Member has the right to request an External Independent Review, as described below.

EXTERNAL INDEPENDENT REVIEW OF DENIED CLAIMS

A request for an external independent review of a denied claim may only be made after the Plan's internal review procedures have been exhausted and must be made within 60 days of receipt of notification of the denial following the internal review.

An external independent review may be requested if the denial was for any the reasons listed below:

1. The service is not Medically Necessary;

2. The service is Experimental/Investigative and the Plan Member has a terminal illness;

3. The service is not covered under the terms of the Plan, but only if the Ohio Department of Insurance has advised the Plan Member that it cannot make a determination because it involves the resolution of a medical issue.

An external independent review may be requested by the Plan Member, an authorized person, the health care provider or the health care facility. However, a health care provider or health care facility must have the Plan Member's authorization to request an external independent review.

A request for an external independent review should state whether an expedited review is being requested. An expedited review is determined within 7 days and all other external independent reviews are determined within 30 days. An expedited review may be requested if delaying the review will do any of the following:

- Place the health of the patient or unborn child in serious jeopardy,
- Cause serious impairment to bodily functions, or
- Cause serious dysfunction of any body part or organ.

A request for an expedited review may be made by phone or fax to EBC. However, it must be followed up by a written request within 5 days. All other requests for external independent reviews must be made in writing. All communications must be to:

Attention: Appeal Dept.
c/o Employee Benefit Consultants, Inc.
215 Stanford Parkway
Findlay, OH 45840
Phone: (800) 472-6630
Fax (419) 423-5834

External independent reviews are conducted by an Independent Review Organization that is appointed by the Department of Insurance. If the Independent Review Organization approves the claim, the Plan will pay the claim, subject to the Plan's Deductibles, Copays and other limitations on payment. If the Independent Review Organization denies the claim, the Plan does not have to provide coverage for the service. The decision by the Independent Review Organization is final. No additional appeals are available.

The Plan Member cannot be required to pay for the review. The review will be paid for by the Plan.

1. Denial Because Services are Not Medically Necessary

A Plan Member may request an external independent review if a claim has been denied because the service is not Medically Necessary and the service and related expenses will cost more than $500 if it is not covered by the Plan.

The request must include a certification from the health care provider that the service will cost the Plan Member more than $500.

2. Denial Because Services are Experimental/Investigative

A Plan Member may request an external independent review of a claim if it has been denied because the service or treatment is considered Experimental/Investigative, the Plan Member has a terminal illness and all of the following requirements have been satisfied:

a. The Plan Member's Physician certifies in writing that the Plan Member has a terminal condition that, according to the current diagnosis of the Physician, has a high probability of causing death within 2 years.

b. The Plan Member's Physician certifies that one of the following situations applies to the Plan Member's condition:

i) Standard therapies have not been effective in improving the Plan Member's condition;

ii) Standard therapies are not medically appropriate for the Plan Member; or

iii) There is not standard therapy covered by the Plan that will benefit the Plan Member more than the therapy requested by either the Plan Member or his/her Physician.

c. The Plan Member's Physician has recommended a drug, device, procedure or other therapy that he/she certifies in writing is likely to benefit the Plan Member more than standard therapies or the Plan Member has requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.

d. The drug, device, procedure or other therapy would be covered if it were not considered to be Experimental/Investigative.

3. Denial Because Services are Not Covered

If the Plan Member requested the Department of Insurance to review a claim that was denied because the service is not covered and the Department of Insurance could not make a determination regarding the claim because it involved the resolution of a medical issue, the Plan Member must request an external independent review in writing within 60 days of the date that the Department of Insurance gave its notice.

RESPONSE OF THE INDEPENDENT REVIEW ORGANIZATION

The Independent Review Organization will provide the Plan Member with a written response, which will include:

1. A description of the Plan Member's condition;

2. The principal reason for the decision; and

3. An explanation of the clinical rationale for the decision.

The decision by the Independent Review Organization is final. No additional appeals are available.