PLAN SPECIFICATIONS

COMPANY	West Noble School Corporation 5050 North U.S. 33 Ligonier, IN 46767
TELEPHONE NUMBER OF PLAN ADMINISTRATOR	(260) 894-3191
PLAN	West Noble School Corporation Employee Benefit Plan. A Grandfathered Plan
PLAN SUPERVISOR	Security Administrative Services, LLC P.O. Box 373 Mishawaka, IN 46546 (574) 296-9990 (800) 550-4115
PARTICIPANT	Eligible employees of West Noble School Corporation as defined herein.
EFFECTIVE DATE	October 1, 1989
REVISION DATE	January 1, 2017
EMPLOYER IDENTIFICATION NUMBER	35-1097836
GROUP NUMBER	2001
PLAN NUMBER	501

WEST NOBLE SCHOOL CORPORATION
EMPLOYEE BENEFIT PLAN

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INTRODUCTION

This Plan Document and Summary Plan Description has been written to provide a clear understanding of the benefits available under this Plan. The benefits as herein described take precedence over, and replace any previous literature furnished.

Except where otherwise indicated by the context, any masculine terminology used herein shall also include the feminine and vise versa, and the definition of any term herein in the singular shall also include the plural and vice versa.

The definition section shall prevail for all purposes within the Plan.

This Plan Document and Summary Plan Description is designed to help you understand your benefit Plan by explaining who is eligible for benefits, when you are eligible for benefits, what your benefits are, and how to file claims for your benefits.

This Plan Document and Summary Plan Description contains all the terms of the Plan and may be amended from time to time by the company or alternatively may be terminated by the company. Any changes so made shall be binding on each covered participant and on any other covered persons referred to in this Plan Document and Summary Plan Description.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how protected health information (or "PHI") may be used or disclosed by us [or your Group Health Plan] to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your PHI, and describes your rights to access, amend and manage your PHI.

PHI is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices had been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact Security Administrative Services, LLC, P.O. Box 373, Mishawaka, IN 46546, 1-800-550-4115.

EFFECTIVE DATE

This Notice of Privacy Practices becomes effective on March 26, 2013.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your PHI. We are obligated to: provide you with a copy of this Notice of our legal duties and of our privacy practices related to your PHI; abide by the terms of the Notice that is currently in effect; and notify you in the event of a breach of your unsecured PHI. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will make the revised Notice available: *by including on the Security Administrative Services, LLC Website and in the Member Handbook*.

Permissible Uses and Disclosures of PHI

The following is a description of how we are most likely to use and/or disclose your PHI.

⇒ Payment and Health Care Operations

We have the right to use and disclose your PHI for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

Payment

We will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your PHI when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

Health Care Operations

We will use or disclose your PHI to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your PHI: (i) to provide you with information about a disease management program; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

Other Permissible Uses and Disclosures of PHI

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your PHI.

⇒ Required by Law

We may use or disclose your PHI to the extent the law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

⇒ Public Health Activities

We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

⇒ Health Oversight Activities

We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

⇒ Abuse or Neglect

We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence.

⇒ Legal Proceedings

We may disclose your PHI: (i) in the course of any judicial or administrative proceeding; (ii) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (iii) in response to a subpoena, a discovery request, or other

lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

⇒ Law Enforcement

Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (i) it is required by law or some other legal process; (ii) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (iii) it is necessary to provide evidence of a crime that occurred on our premises.

⇒ Coroners, Medical Examiners, Funeral Directors; Organ Donation Organizations

We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

⇒ Research

We may disclose your PHI to researchers when an institutional review board or privacy board has: (i) reviewed the research proposal and established protocols to ensure the privacy of the information; and (ii) approved the research.

⇒ To Prevent a Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

⇒ Military Activity and National Security, Protective Services

Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

⇒ Inmates

If you are an inmate of a correctional institution, we may disclose your PHI to the correctional institution or to a law enforcement official for: (i) the institution to provide health care to you; (ii) your health and safety and the health and safety of others; or (iii) the safety and security of the correctional institution.

⇒ Workers' Compensation

We may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

⇒ Emergency Situations

We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will disclose only the PHI that is directly relevant to the person's involvement in your care.

⇒ Fundraising Activities

We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

⇒ Group Health Plan Disclosures

We may disclose your PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to you. We can disclose your PHI to that entity if that entity has contracted with us to administer your health care program on its behalf.

⇒ Underwriting Purposes

We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing in the underwriting process your PHI that is genetic information.

⇒ Others Involved in Your Health Care

Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law.

If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

Uses and Disclosures of Your PHI that Require Your Authorization

Sale of PHI

We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing

We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes

We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

Required Disclosures of Your PHI

The following is a description of disclosures that we are required by law to make.

⇒ Disclosures to the Secretary of the U.S. Department of Health and Human Services

We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

⇒ Disclosures to You

We are required to disclose to you most of your PHI in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

We will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose PHI to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

⇒ Business Associates

We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management. Examples of our business associates would be our Third Party Administrator, Security Administrative Services, LLC, which will be handling many of the functions in connection with the operation of our Group Health Plan; the retail pharmacy; and the mail order pharmacy.

⇒ Other Covered Entities

We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

⇒ Plan Sponsor

We may disclose your PHI to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

Potential Impact of State Law

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

YOUR RIGHTS

The following is a description of your rights with respect to your PHI.

⇒ Right to Request a Restriction

You have the right to request a restriction on the PHI we use or disclose about you for payment or health care operations. *We are not required to agree to any restriction that you may request.* If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you. You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for restriction to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

⇒ Right to Request Confidential Communications

If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for confidential communications to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your PHI with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger.

We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your PHI could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for

payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (*e.g.*, an Explanation of Benefits, or "EOB"). *Unless* you have made other payment arrangements, the EOB (in which your PHI might be included) will be released to the plan participant.

Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within five business days.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI might be disclosed (such as through an EOB). Therefore, it is extremely important that you contact the designated contact listed on the first page of this Notice *as soon as* you determine that you need to restrict disclosures of your PHI.

If you terminate your request for confidential communications, the restriction will be removed for *all* your PHI that we hold, including PHI that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your PHI will endanger you.

⇒ Right to Inspect and Copy

You have the right to inspect and copy your PHI that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your PHI that is contained in a designated record set, you must submit your request to the designated contact listed on the first page of this Notice. It is important that you contact the designated contact to request an inspection and copying so that we can begin to process your request. Requests sent to persons, offices, other than the designated contact might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact the designated contact listed on the first page of this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

⇒ Right to Amend

If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by contacting the designated contact listed on the first page of this Notice. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to the designated contact so that we can begin to process your request. Requests sent to persons or offices, other than the designated contact might delay processing the request.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

⇒ Right of an Accounting

You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing to the designated contact listed on the first page of this Notice. It is important that you direct your request for an accounting to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

⇒ Right to a Copy of This Notice

You have the right to request a copy of this Notice at any time by contacting the designated contact listed on the first page of this Notice. If you receive this Notice on our Website or by electronic mail, you also are entitled to request a paper copy of this Notice.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at the number listed on the first page of this Notice. A copy of a complaint form is available from this contact office.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or any other way retaliate against you for filing a complaint with the Secretary or with us.

CLAIM FILING PROCEDURE

Security Administrative Services, LLC processes your claims.

PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY. THIS WILL ASSURE PROMPT PAYMENT OF YOUR CLAIMS.

A. MEDICAL EXPENSES

1. Hospital services (in- or outpatient)

   When hospital services are rendered, present your identification card. The hospital will send the bill to the Preferred Provider Organization (PPO). Security Administrative Services, LLC (SAS) will send the payment directly to the hospital.

2. Prescriptions drugs.

   Pharmacies – present your I.D. card, and pay any applicable co-payment.
   Mail Service – Refer to the mail service drug program brochure for instructions.

3. PPO providers (in-network).

   Present your medical identification card. The PPO provider will submit the bill to the PPO. The PPO will forward the bill to SAS to process.

4. All other providers (out-of-network).

   Have the provider of service send the itemized bill to the PPO as directed on your medical identification card. Be sure the following is included on the bill.

   a. Employee's name

   b. Employee's Social Security Number

   c. Name of the Patient

   If the bill is sent to your home, submit the itemized bill to the PPO as directed on your medical identification card.

5. Original bills

   Submit only the bills. Keep copies for your records or your spouse's insurance. Copies will be accepted only if the your Employer's plan is secondary in coordination.

6. Itemized Bills

Your Plan requires that all bills be itemized. Security Administrative Services, LLC will process only itemized bills.

The bill must include:

a. Patient's name;

b. Date of services;

c. Services rendered;

d Amount charged for each services performed; and

e. Diagnosis – VERY IMPORTANT

8. Accident expenses

Obtain the accident claim form from your employer. Accident-related bills must have the following information: WHEN, WHERE AND HOW THE ACCIDENT HAPPENED.

THE BILL(S) WILL NOT BE PROCESSED WITHOUT THIS INFORMATION.

B. AUTOMATIC ASSIGNMENT OF BENEFITS

1. Unpaid bills – Payment of all unpaid bills will be made payable to the provider of service and mailed to the provider.

2. Paid bills – Payment of all paid bills will be made payable to the employee and mailed to the employee. If you have paid the bill, be sure "paid" is indicated on the bill.

C. EXPLANATION OF BENEFITS

Each time SAS processes a claim for you or a member of your family, they will respond with an Explanation of Benefits informing you what the charges were, how the charges were paid, and to whom the payments were made.

D. CLAIMS APPEAL PROCESS

The Plan has a claims appeal process. The claims appeal process and the time limits associated with requesting and responding to a request for Claims Appeal are described in this section. The Covered Employee and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office.

Under the Plan, the Covered Employee can check on the status of a claim appeal at any time by contacting the Customer Service number appearing on the reverse side of the identification card.

Requesting a Claims Appeal - The Plan has a claims appeals process that allows the Covered Employee to submit a request for appeal to the fiduciary who has been named by the Plan Administrator to review a claims appeal ("Named Fiduciary"). Under the Plan, the Plan Administrator will serve as the Named Fiduciary, unless the Plan Administrator has specifically delegated this responsibility to another party. The Named Fiduciary has the sole responsibility for making the decision on an appeal of an adverse benefit determination.

Under the claims appeal process, the Covered Employee will be provided with a full and fair review of an adverse benefit determination. This review of an adverse benefit determination must be done by an individual who is neither the individual who made the original adverse benefit determination nor the subordinate of such individual. In addition, if the adverse benefit determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not Medically Necessary, the Named Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

In the event the Covered Employee disagrees with a claims decision concerning the denial of a benefit or scope of benefits, the Covered Employee or the Covered Employee's authorized representative may submit a request for appeal within 180 days from receipt of the notice of denial or adverse benefit determination. Absent an express written authorization by the Covered Employee providing otherwise, the authorized representative includes a medical provider only for an Urgent Care Claims Appeal.

Under the claims appeal process:

1. The Covered Employee is permitted to submit written documents, comments, records and other information relating to the claim;
2. The Covered Employee is allowed reasonable access to any copies of documents, records and other information relevant to the claim;
3. The Covered Employee is permitted to request the name of the medical provider used in making the initial adverse benefit determination; and
4. All comments, documents, records and other information submitted without regard to whether such information was submitted or considered in the initial determination will be taken into account.

The Covered Employee's request for an appeal of an adverse benefit determination for Pre-Service and Post-Service Claims must be submitted in writing and should be submitted to:

Security Administrative Services, LLC
P.O. Box 373
Mishawaka, IN 46546

For appeal of an Urgent Care Claim, the request for appeal may also be submitted verbally to Security Administrative Services, LLC 1-800-550-4115

If the Covered Employee's request for appeal is not submitted in the manner described in this section, it will not be considered a "claims appeal" under the Plan.

Under this Plan, Security Administrative Services, LLC is not the Named Fiduciary for purposes of reviewing claims appeals under the Plan, but is instead acting strictly at the request of the Plan Administrator to coordinate receipt of appeals on behalf of the Plan.

Time Frame for Claims Appeal Review For Pre-Service Claim - All Pre-Service Claim Appeals will be reviewed and written notification of the Named Fiduciary's decision will be prepared and mailed to the Covered Employee who submitted the claim appeal within 30 days of receiving the request for appeal of a Pre-Service Claim. As used in this section, a Pre-Service Claim Appeal is an appeal for any adverse claims determination in connection with a Pre-Service Claim.

Time Frame for Claims Appeal Review For Post-Service Claim: All Post-Service Claim Appeals will be reviewed and written notification of the Named Fiduciary's decision will be prepared and mailed to the Covered Employee who submitted the claims appeal within 60 days of receiving the request for appeal of a Post-Service Claim. As used in this section, a Post-Service Claim Appeal is an appeal for any adverse claims determination in connection with a Post-Service Claim.

Note: If the Plan Fiduciary is a multi-employer plan which has a committee or board of trustees designated as the appropriate Named Fiduciary which holds regular meetings (at least once a quarter), and if the appeal request is received within 30 days preceding the date of the next scheduled meeting, then the Named Fiduciary will make the determination concerning the claims appeal no later than the date of second meeting following receipt of the request. If special circumstances (such as the need to hold a hearing, if the Plan's procedures allow for such a hearing) require a further extension of time for processing an appeal request, a determination shall be rendered not later than the third meeting of the committee or board of trustees following the Plan's receipt of the request for review. In this instance, the Plan Administrator shall provide to the Covered Employee written notification of the extension and such notice shall describe the special circumstances and the date as of which the determination will be made, prior to the commencement of the extension. The Covered Employee will be notified of the Named Fiduciary's decision concerning the appeal no later than 5 days after the determination is made by Named Fiduciary.

Time Frame for Claims Appeal Review for Urgent Care Claim – An Urgent Care Claim Appeal will be reviewed immediately and the Covered Employee will be notified of the Named Fiduciary's decision within 72 hours of receiving the request for appeal. Because of the urgency related to Urgent Care Appeals, all notifications concerning an appeals decision may be made verbally, or by fax or other electronic means. As used in this section, an Urgent Care Claim Appeal is an appeal for any adverse claims determination in connection with an Urgent Care Claim.

Information Included in an Adverse Appeal Determination - All adverse appeal determinations will include the following information:

1. The reason for the determination;
2. Reference to the specific plan provision(s) on which the benefit determination is based;
3. A statement that the Covered Employee is entitled to receive free of charge access to and copies of documents and records pertinent to the claim;
4. A statement of the Covered Employee's right to bring civil action under ERISA section 502(a), which right only applies if the Plan is an ERISA plan;
5. A statement of the Covered Employee's right to obtain free of charge, internal rules, guidelines, protocols, or other similar criterion used in making the adverse determination; and
6. Either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan, or a statement that such explanation may be obtained free of charge upon request if the claim was denied on the basis of Medical Necessity or Experimental or Investigative grounds.

The decision of the Named Fiduciary with regard to an appeal is final.

WEST NOBLE SCHOOL CORPORATION
SCHEDULE OF BENEFITS
MEDICAL BENEFITS

	P.P.O. NETWORK	**NON-NETWORK**
Calendar Year Deductible	$1,500 Single Coverage	$3,000 Single Coverage
	$3,000 Family Coverage	$6,000 Family Coverage
Hospital Pre-Certification Program Refer to Section II	The plan requires that prior to any elective or scheduled Hospital confinement, Outpatient Imaging for MRI's CAT Scans, PET Scans, SPECT Scans and Outpatient Surgery the employee or his Physician must obtain pre-certification by calling the phone number on the I.D. card (within 2 workdays of an emergency or weekend Hospital admission). Failure to have any Inpatient Hospital admission pre-certified will result in a penalty of $250 per admission. This penalty will be waived for all outpatient procedures.	
Lifetime Maximum	Unlimited	

	P.P.O. NETWORK	**NON-NETWORK**
Maximum Out-of-Pocket (Including the Deductible)		
Single Coverage	$ 1,500	$ 3,000
Family Coverage	$ 3,000	$ 6,000

NOTE: Please refer to Health Reimbursement Account (HRA) Document for details relating to reimbursement of eligible deductible expenses.

Room and Board and Miscellaneous Charges	100% of Eligible Expenses subject to the deductible.	100% of Eligible Expenses subject to the deductible.
Surgery (Doctor charges)	100% of Eligible Expenses subject to the deductible.	100% of Eligible Expenses subject to the deductible.
Doctor Office Visits	100% of Eligible Expenses subject to the deductible.	100% of Eligible Expenses subject to the deductible.
Preadmission Testing	100% of Eligible Expenses not subject to the deductible.	100% of Eligible Expenses not subject to the deductible.
Emergency Room Charges	100% of Eligible Expenses subject to the deductible.	100% of Eligible Expenses subject to the deductible.
Urgent Care Centers	100% of Eligible Expenses subject to the deductible.	100% of Eligible Expenses subject to the deductible

	P.P.O. NETWORK	NON-NETWORK
X-Ray/Lab Charges	100% of Eligible Expenses subject to the deductible.	100% of Eligible Expenses subject to the deductible.
Surgery Performed At Doctor's Office (Includes Doctor Charges)	100% of Eligible Expenses and the deductible is waived.	100% of Eligible Expenses and the deductible is waived.
Facility and Doctor Charges (Other Than in Doctor's Office)	100% of Eligible Expenses and the deductible is waived.	100% of Eligible Expenses and the deductible is waived.
Services Received in a Network Facility	If a covered person goes to a Network Facility and receives care and treatment by a Provider that is not of his choice and is not part of the Network, those charges will be reimbursed as if rendered by a Network Provider.	
Drug Card/Mail Order Program	4D Pharmacy / Magellan PHARMACY / WELLDYNERX	

Co-Payment Per Prescription

Retail Pharmacy 1-30 day supply
- Generic - $4.00
- Formulary Brand - $20.00
- Non-Formulary Brand - $40.00

Retail Pharmacy 31-90 day supply
- Generic - $10.00
- Formulary Brand - $50.00
- Non-Formulary Brand - $100.00

Mail Order 1-90 day supply
- Generic - $10.00
- Formulary Brand - $50.00
- Non-Formulary Brand - $100.00

The plan only pays a generic benefit when a brand medication is purchased that has a generic available. Member will be responsible for the cost difference between the brand and generic product, plus the applicable copay even if the doctor requires that a brand medication be filled when a generic is available.

NOTE: Injectable medications (other than products like insulin, epi-pens, etc.) are not covered under the prescription benefit. They may be covered under major medical coverage.

Include DAW 1 and 2 edits at retail and mail order as part of the program.

	P.P.O. NETWORK	NON-NETWORK
Mental Illness		
Inpatient Facility	100% of Eligible Expenses, subject to the deductible.	100% of Eligible Expenses, subject to the deductible.
Outpatient Visits	100% of Eligible Expenses subject to the deductible.	100% of Eligible Expenses subject to the deductible.
Substance Abuse		
Inpatient Facility	100% of Eligible Expenses, subject to the deductible.	100% of Eligible Expenses, subject to the deductible.
Outpatient Visits	100% of Eligible Expenses subject to the deductible.	100% of Eligible Expenses subject to the deductible.
Wellness Program	. The Plan will reimburse 100 % of Eligible Expenses subject to the following limits: - During the first two (2) years of life, well baby care physicals and immunizations will be considered as eligible expenses under the Plan. - Basic annual physical exams for men and women age 18 and over will include those items as identified under the annual physical exam form. Please refer to appendix A at the back of your booklet. NOTE: The annual maximum benefit payable for wellness exams is $300.00 per covered person.	

OTHER BENEFITS

	P.P.O NETWORK	NON-NETWORK
Ambulance Service	100% of Eligible Expenses subject to the deductible.	100% of Eligible Expenses subject to the deductible.
Emergency Medical Treatment	In the event medical treatment, or for participants living outside of the network area, expenses will be considered and paid as an IN-Network expense. This provision will apply whether any or all providers are part of the PPO Network. This provision will also apply in the event transfer of the patient to another out of network facility is necessary in order to properly treat the patient. This provision will not apply for any participant who elects to travel outside of the PPO network in order to seek medical treatment.	
Medical Aids	100% of Eligible Expenses subject to the deductible.	100% of Eligible Expenses subject to the deductible.
Infertility Treatment	100% of Eligible Expenses subject to the deductible. Benefits will be limited to a maximum payment of $20,000 per calendar year.	100% of Eligible Expenses subject to the deductible. Benefits will be limited to a maximum payment of $20,000 per calendar year.
Second Surgical Opinion	100% of Eligible Expenses the deductible is waived.	100% of Eligible Expenses the deductible is waived.
Temporomandibular Joint Dysfunction (TMJ)	100% of Eligible Expenses subject to the deductible.	100% of Eligible Expenses subject to the deductible.
Home Health Care	100% of Eligible Expenses subject to the deductible. Benefit Maximum: - 40 visits per calendar year of non custodial care. - maximum payment of $40 per visit.	100% of Eligible Expenses subject to the deductible. Benefit Maximum: - 40 visits per calendar year of non custodial care. - maximum payment of $40 per visit.
Hospice Care	100% of Eligible Expenses subject to the deductible. Benefit Maximum: - 6 month benefit period two (2) benefit periods per lifetime. - maximum payment per benefit period of $4,500.	100% of Eligible Expenses subject to the deductible. Benefit Maximum: - 6 month benefit period two (2) benefit periods per lifetime. - maximum payment per benefit period of $4,500.

	P.P.O NETWORK	NON-NETWORK
Skilled Nursing Facility	100% of Eligible Expenses subject to the deductible.	100% of Eligible Expenses subject to the deductible.
Organ Transplant Expense Benefit	100% of Eligible Expenses Subject to the deductible. Organ transplants considered experimental in nature are excluded under the plan, and eligible donor expenses are limited to a maximum payment of $5,000.	100% of Eligible Expenses subject to the deductible. Organ Transplants considered experimental in nature are excluded under the plan, and eligible donor expenses are limited to a maximum payment of $5,000.
Chiropractic Services	100% of Eligible Expenses subject to the deductible. - Maximum of 52 visits per calendar year. - Maximum of one (1) visit per day.	100% of Eligible Expenses subject to the deductible. - Maximum of 52 visits per calendar year. - Maximum of one (1) visit per day.
Supplemental Accident	100% of the first $300 of Eligible Expenses incurred within the first 90 days following the date of the accidental bodily injury. The balance of the expenses will be subject to the deductible and out-of-pocket amounts.	100% of the first $300 of Eligible Expenses incurred within the first 90 days following the date of the accidental bodily injury. The balance of the expenses will be subject to the deductible and out-of-pocket amounts.

ADDITIONAL PROVISIONS

Medicare	Coordination
Waiting Period	Coverage begins immediately upon the date of employment. Eligible employees will be defined through employer contract requirements.
Pregnancy	Covered the same as any other condition for: Female Employees Wives of Male Employees Dependent children are excluded.
Annual Open Enrollment Period	The plan will adopt an annual enrollment period. The time period will be annually each December. Those electing to make changes in their enrollment status will have those change take effect January 1 of each year.
Dependent Child Maximum Age	Coverage will terminate upon the attainment of age twenty six (26) Refer to Section 7.04 for additional details.
Hospital Bill Audit Reward	Hospital billing errors identified and corrected by the employee are eligible for a reward payment in cash to the employee. The amount of the reward will be equal to 50% of the error corrected to a maximum of $200 per hospital confinement.

Coverage to Retirees
(Indiana Code)
5-10-8-26 or Similar
Codes as Amended

To be eligible the retired participant must meet each of the following requirements:

1.. he must have reached age 55 on or before his retirement date but will not be eligible for Medicare, and

2. he must have completed 10 consecutive years of service which must have been completed immediately prior to his retirement date with West Noble School Corporation, and completed a total of 20 years of creditable employment with public employer, and

3. he must have completed at least 15 years of participation in the Employer's retirement plan of which he was a member on or before his retirement date.

The retired participant must make a written request for the continuation of coverage to the Employer within 90 days after his retirement Date and the Employer may require that the retired participant pay for all or a portion of the cost of the coverage. The retired participant's coverage shall terminate herein upon the earlier of:

1. the date the retired participant become eligible for Medicare, or;

2. the date the Employer ceases to maintain the Plan.

A retired participant who is eligible for coverage herein may elect the same coverage for his dependent spouse at the time of the participant's retirement. The Employer may require that the dependent spouse pay for all or a portion of the cost of the coverage.

If the dependent spouse pays the entire cost of the coverage, then his/her eligibility for coverage herein shall not be affected by death of the retired participants. The surviving dependent spouse's coverage shall terminate upon the earliest of the following:

1. when the surviving dependent spouse becomes eligible for Medicare; or

2. when the Employer ceases to maintain the Plan; or

3. two (2) years after the retired participant's death; or

4. the date of the surviving spouse's remarriage; or

5. the remaining spouse's eligibility terminates.

SECTION II

HOSPITAL PRECERTIFICATION PROGRAM

2.01 The following medical review services will be provided under this program:

a. Pre-Admission Certification
b. Continued Stay Review
c. Medical Case Management
d. Mandatory Reductions

Penalties for non-use of these services are listed under Mandatory Reductions.

2.02 PRE-ADMISSIONS CERTIFICATION

Expenses incurred in connection with a hospital confinement for a non-emergency inpatient admission shall be subject to a mandatory Pre-Admission Certification. The patient or the patient's attending physician must make this notification.

Expenses incurred in connection with a hospital confinement for an emergency admission also require that be notified by the physician, patient, or patient's family within 24 hours, or by the next working day if admission occurs over a weekend.

After discussion with the attending physician, a Medical Review Specialist will review the medical information and evaluate it against established medical criteria to determine the medical necessity and appropriateness of inpatient admission and the proposed treatment plan. If information available meets such medical criteria, Pre-Admission Certification will be granted.

If such medical criteria are not met, the case will be referred to a Physician Advisor of the appropriate medical specialty. If the Physician Advisor determines the admission is medically justified the attending physician will be advised. If the medical necessity of the admission is questionable, the Physician Advisor will contact and discuss the case with the attending physician.

If the Physician Advisor recommends a denial of admission, this information shall be communicated to the attending physician who may agree and alter the treatment plan. If the attending physician disagrees, the medical information will be referred to a second Physician Advisor who will then make a determination as to the medical necessity of admission.

If the second Physician Advisor agrees with the attending physician, the recommendation for approval shall be made. If both Physician Advisors disagree with the attending physician, the recommendation for denial will be made and all parties will be notified.

2.03 CONTINUED STAY REVIEW

Continued Stay Review will begin as an immediate follow-up to Pre-Admission Certification. Using established medical criteria and internally developed length of stay norms, the pre-certification company will determine the medical necessity and appropriateness of the treatment plan and inpatient stay.

At intervals throughout a covered person's hospital stay, a Medical Review Specialist will contact the attending physician for an update of the patient's progress, treatment and discharge plans. If the established medical criteria continue to be met, additional days of continued stay will be certified and the date for the next review will be established with the attending physician.

If such criteria are not met, the case will be referred to a Physician Advisor of the appropriate medical specialty. If the Physician Advisor recommends approval of stay, the attending physician will be notified and advised of the next review date. If the Physician Advisor feels denial should be recommended, he will contact the attending physician. If the attending physician agrees with the recommendation for denial, the attending physician will arrange for discharge.

If the attending physician disagrees with the Physician Advisor's denial of stay recommendation, a second Physician Advisor of the same medical specialty will be called in to decide by either agreeing with the attending physician or the first Physician Advisor's recommendation for denial.

Prompt notifications will be made both in writing and by phone to the patient, the attending physician, and to the hospital if there is a recommendation for denial of continued stay.

2.04 MEDICAL CASE MANAGEMENT

The Plan reserves the right to secure Medical Case Management, Claim Edit, Bill Review and Secondary Network Negotiations for serious or chronic illness conditions assuring quality and appropriateness of medical treatment, and placement in an appropriate treatment facility. The pre-certification company will facilitate appropriate utilization of therapies, home care, rehabilitation and terminal care.

2.05 MANDATORY REDUCTIONS

Failure to comply with the requirements established will result in a reduction of covered expenses of $250 per hospitalization. Payment of these expenses will be the responsibility of the employee and will not apply to the deductible or coinsurance.

PLEASE CALL THE PRECERTIFICATION PHONE NUMBER IDENTIFIED ON YOUR I.D. CARD.

SECTION III

PARTICIPANT AND DEPENDENT COVERAGE

3.01 PARTICIPANT COVERAGE

a. General

A participant becomes eligible for coverage under the Plan on his (I) Eligibility Date (ii) on the date he enters an eligible class of employees, or (iii) on the Effective Date of the Plan, whichever is latest. The following determinations shall apply:

"Effective Date" - An eligible participant must complete and deliver to the Plan Administrator an application on a form supplied by the Plan Supervisor, and coverage becomes effective on the date the participant becomes eligible.

"Eligibility Date" - A participant becomes eligible for coverage hereunder after satisfying the Waiting Period as shown in the Schedule of Benefits.

b. Special Rules

1. If the participant does not meet both of the following requirements on the date any of his coverage would otherwise become effective for him, the effective date of the coverage will be delayed until the date he meets both of such requirements:

   The participant is away from work on the original effective date of coverage for reasons other than health related factors.

   The participant is regularly working the Plan Administrator's customary work week for a full-time employee at any of the Plan Administrator's business establishments.

2. ELIGIBILITY DETERMINATIONS UNDER HIPAA

   Federal Law, under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), prohibits the Plan Sponsor from denying Coverage under the Plan based on any of the following health-related factors:

   a. Health status;
   b. Medical condition (including both physical and mental illnesses);
   c. Receipt of healthcare;
   d. Medical history;
   e. Genetic information;
   f. Evidence of insurability (including conditions arising out of acts of domestic violence); and
   g. Disability.

c. New Hires

Regular Full-time Employees: Employees designated by the Employer as Regular Full-time employees. Coverage for Regular Fulltime Employees, if properly elected, will be effective following the waiting period.

Qualifying Part-time Employee: Any other Employees, including but not limited to Seasonal Employees, who are not Regular Full-time Employees to the extent that such Employees average 30 hours of service per week over the employee's applicable Initial Measurement Period (as defined in the Plan Eligibility Appendix adopted by the Employer). Coverage for such Employees, if properly elected, will be effective on the first day of the Qualifying Part-time Employee's New Employee Stability Period (as defined by the Plan). A Qualifying Part-time Employee will remain eligible throughout the New Employee Stability Period to the extent that the employee remains employed, subject to the Plan's Break in service (as defined by the Plan) rules.

Note: if there is a gap between the end of the Qualifying Part-time Employee's New Employee Stability Period and the start of the Qualifying Part-time Employee's first Ongoing Employee Stability Period (see below), the Qualifying Part-time Employee will remain eligible under the Plan until the day preceding the start of the Ongoing Employee Stability Period to the extent the employee remains employed, subject to the Plan's Break in Service rules.

If a Qualifying Part-time Employee transfers to a Regular Full-time Employee position prior to the start of the Qualifying Part-time Employee's New Employee Stability Period, the Employee will become eligible for coverage. If elected, coverage for such new Regular Full-time Employee will become Eligible

(effective date following any waiting period).

"Ongoing" Employee's

Once an Employee has completed the Plan's Standard Measurement Period, eligibility will be based solely on the Employee's Hours of Service during the Plan's Standard Measurement Period. Any Employee who averages 30 Hours of service per week during the Plan's Standard Measurement Period (Ongoing Employee's) will be eligible for coverage under the Plan during the Plan's next Ongoing Employee Stability Period to the extent that the Ongoing Employee remains employed, subject to the Plan's Break in Service rules. Such coverage, if elected, will be effective on the first day of the Plan's Ongoing Employee Stability Period.

Whether an Employee averages 30 Hours of Service per week will be determined in accordance with policies and procedures adopted by the Plan Administrator.

Impact of Breaks in Service:

Any Employee who resumes Hours of Service following a break in Service (as defined in the Plan Eligibility Appendix) will be treated as a New Hire and eligibility for coverage under the Plan upon return will be determined in accordance with the New Hire rules above. If, however, the Employee experiences a period without any Hours of Service, and resumes Hours of Service without experiencing a Break in service, the Employee will be treated as a continuous employee. A continuous employee resuming

Hours of Service after a period with no Hours of Service that does not constitute a Break in Service will be eligible for coverage under the Plan upon return if they were enrolled in coverage prior to the start of the period with No Hours of Service. Such coverage will be effective on the first day of the month that coincides with or follows the date you resume Hours of Service.

3.02 DEPENDENT COVERAGE

A Dependent will be considered eligible for coverage on the date the Participant becomes eligible for Dependent Coverage, subject to all limitations and requirements of this Plan, and in accordance with the following:

1. Newborn or newly adopted children of a covered Participant will be covered from the moment of birth or placement for adoption for Injury or Illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled as a Dependent of the Participant within thirty-one (31) days of the child's date of birth or placement for adoption. This provision shall not apply to or in any way affect the normal maternity provisions applicable to the mother.

2. A Spouse will be considered an eligible Dependent from the date of marriage, provided the Spouse is properly enrolled as a Dependent of the Participant within thirty-one (31) days of the date of marriage.

3. If a Dependent is acquired other than at the time of his birth, due to a court order, decree, or marriage, that Dependent will be considered an eligible Dependent from the date of such court order, decree, or marriage, provided that this new Dependent is properly enrolled as a Dependent of the Participant within thirty-one (31) days of the court order, decree, or marriage.

4. A child may become eligible for Dependent Coverage as set forth in a qualified medical child support order. The Plan Administrator will establish written procedures for determining (and shall have sole discretion to determine) whether a medical child support order is qualified and for administering the provision of benefits under the Plan pursuant to a qualified medical child support order. The Plan Administrator may seek clarification and modification to the order, up to and including the right to seek a hearing before the court or agency which issued the order.

3.03 LATE ENROLLMENT

If the participant's request for enrollment for participant or dependent coverage is made later than thirty-one (31) days after the participant is first eligible for participant or dependent coverage, or if the participant's earlier application for participant or dependent coverage has been disapproved or limited in any way by the Plan Administrator, the person wishing to be enrolled in the Plan for participant or dependent coverage must comply with the procedure outlined in section 3.04. Coverage may begin only when and if the Plan Administrator approves the application for enrollment for participant or dependent coverage. If application is made after the initial date of eligibility (other than during a special enrollment period available to Special Enrollees), the Participant shall be a Late Enrollee and, coverage for the eligible Employee shall not become effective until the end of the next Enrollment Period as state in the Schedule of Benefits.

Except as otherwise provided under "Dependent Eligibility" (i.e., for newborn, adopted, and newly acquired dependents) or as provided under "Special Enrollment Date" below, if the Participant makes such written request after the date on which he is both eligible for Dependent Coverage and is Actively at Work, those persons who are then his Dependents shall be Late Enrollees, and coverage for the eligible Dependent shall not become effective until the end of the next Enrollment Period as stated in the Schedule of Benefits.

3.04 SPECIAL ENROLLMENT DATE

If an eligible Employee or Dependent declined coverage hereunder at the time of initial eligibility (and stated in writing at that time that coverage was declined because of alternative health coverage) but subsequently loses coverage under the other health plan and makes application for coverage hereunder within thirty-one (31) days of the loss, such individual shall be a Special Enrollee provided such person: (a) was under a COBRA continuation provision and the coverage under such provision was exhausted; or (b) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated. Individuals who lose other coverage due to nonpayment of premium or for cause (e.g., filing fraudulent claims) shall not be Special Enrollees hereunder. An eligible Employee or Dependent who seeks to enroll in the Plan as a result of the acquisition of a new Dependent through marriage, birth, adoption or placement for adoption shall be a Special Enrollee hereunder if the eligible Employee or Dependent enrolls within 30 days of the acquisition of the new Dependent. This time period is extended to 60 days for dependents being added to the Plan through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Coverage for a Special Enrollee (other than a Newborn or newly adopted child) shall begin as of the first day of the calendar month following the enrollment request. Coverage for a newly adopted or Newborn Special Enrollee shall begin as of the first date of the adoption, birth, or placement for adoption.

3.05 TERMINATION DATES OF COVERAGE

The coverage for covered participants and their dependents under the Plan will terminate on the earliest of the following dates.

a. The date of termination of the Plan;

b. The date of the Plan Month in which he requests such coverage be terminated;

c. The expiration of the last period for which the employee has made a contribution in the event of the employee's failure to make such contributions.

d. The date of the Plan Month in which he ceases to be eligible for such coverage under the Plan. In the event of a dependent the date the dependent ceases to be a dependent as defined in the Plan.

e. The date of the Plan month in which the termination of his employment occurs. Termination of employment means cessation of active work.

f. Leave of Absence Provision – Such coverage will be maintained for any participant who qualifies under the provisions established by the Family and Medical Leave Act of 1993. All previous provisions including Coverage Under this Plan, Effective Date of Coverage, and Termination of Coverage are intended to be in compliance with the Family and Medical Leave Act of 1993 (FMLA). To the extent the FMLA applies to the Company, group health benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, the obligations of the Employer and employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA. Any plan provisions which conflict with the FMLA is superseded by the FMLA to the extent such provisions conflict with the FMLA.

Notwithstanding anything in this Plan to the contrary, with respect to any Employee or Dependent who loses coverage under this Plan during the Employee's absence from employment by reason of military service, no Waiting Period may be imposed upon the reinstatement of such Employee's or Dependent's coverage upon re-employment of the Employee unless such Waiting Period would have otherwise applied to such Employee or Dependent had the Employee not been on military leave of absence.

SECTION IV
DESCRIPTION OF BENEFITS

4.01 ELIGIBLE EXPENSES

The services described in this Section IV are eligible expenses for participants and dependents covered under this Plan. Eligible expenses are subject to the deductible and coinsurance percentage as shown in the Schedule of Benefits and are limited by certain provisions set forth in the General Exclusions in Section 6 of this Plan.

4.02 HOSPITAL INPATIENT EXPENSES

The Plan covers the following Hospital inpatient expenses:

a. Hospital Room and Board - An amount per day up to the semi-private room rate. This will also include the expenses of an Intensive Care Unit (ICU) when ordered by the patient's primary physician but such expenses shall not exceed the average room rate for such accommodations.

b. Hospital Miscellaneous - All other charges made by a hospital during an inpatient confinement, exclusive of personal items or services not necessary to the treatment of illness or injury.

4.03 EXPENSES IN OR OUT OF THE HOSPITAL

The Plan covers certain expenses whether in or out of the Hospital including but not limited to:

a. Hospital Outpatient Service

b. X-Ray and Laboratory Services

c. Surgery Charges

d. Anesthesia Charges

e. Services of other Physicians including:

i) * Radiation Therapy

ii) * Pathological Services

iii) * Electrocardiograms

iv) * Physical Therapy

v) * Electroencephalograms

vi) * Hospital Visits

vii) * Assistant Surgeon Charges

f. Other Services

i) Nursing Services (except those of a relative) of a Registered Nurse (R.N.), or a Licensed Practical Nurse (L.P.N.).

ii) Rental or purchase, whichever is more economical, of medically necessary durable medical equipment.

iii) Functional Prosthetic Appliances (artificial limbs, braces)

iv) Non-functional Prosthetic Appliances (artificial eyes, ears, noses) and orthopedic appliances

v) Corrective Shoes

vi) Professional ambulance service (including air ambulance) used locally to and from the Hospital, in connection with an inpatient admission or in connection with outpatient care of an injury.

vii) Private Duty Nursing (up to forty-five (45) days per calendar year for inpatient admissions only)

viii) Cervical collar, colostomy bag, ileostomy supplies, catheters, insulin and syringes

ix) Contact lenses, following cataract surgery

x) Allergy testing

xi) Blood and blood syringes

xii) Oxygen and other gas therapy

xiii) Speech and Hearing Therapy

xiv) Dental Services provided by a dentist, oral surgeon, or physician, including all related charges, only as specifically provided herein:

A. Repair to natural teeth due to accidental injury within ninety (90) days of the accident;

B. Oral surgical procedures prescribed by a dentist which could commonly be performed by a physician such as gingivectomies, alveolectomies, alveoplastics, and reduction of fractures or dislocations of the jaw.

xv) Injectable medications are covered up to the reasonable and customary charges for the particular injectable medication being administered. Reasonable and customary as it relates to injectable medications is the average wholesale price (AWP) of the medication being administered as determined by a nationally recognized source at the discretion of the plan administrator. The Plan Administrator will be allowed to negotiate with the provider involved and reserves the right to accept the provider's documented pricing practices in the event reasonable and customary pricing is not established.

4.04 EXPENSES OUT OF THE HOSPITAL - The Plan covers certain expenses out of the Hospital including but not limited to:

a. Prescription drugs requiring a prescription under Federal Law
b. Physician's office call
c. Physician's office surgery

4.05 DEDUCTIBLE

Participants and dependents covered under the Plan must meet an amount of eligible expenses each calendar year equal to the deductible amount as shown in the Schedule of Benefits before Major Medical benefits can be paid.

4.06 FAMILY DEDUCTIBLE

When a family meets the family deductible amount shown in the Schedule of Benefits, the individual deductible for all other covered members in the family will be satisfied for the remainder of the calendar year.

4.07 COMMON ACCIDENT

When two or more covered family members are injured in the same accident, only one deductible amount applies to all eligible expenses for treatment resulting from that accident.

4.08 COINSURANCE PERCENTAGE

After eligible expenses incurred in a calendar year equal the deductible amount, eligible expenses incurred in that calendar year shall be paid at the Coinsurance Percentage as specified in the Schedule of Benefits. In the event the Plan provides a different coinsurance percentage for In-Network versus Out-of-Network the Out-of-Pocket amounts will be commingled. The Out-of-Network penalty will be the difference between the amounts stated in the Schedule of Benefits.

4.09 INPATIENT ALCOHOLISM AND DRUG ABUSE BENEFIT

Eligible expenses for INPATIENT treatment of alcoholism and drug abuse shall be paid the same as any other hospital confinement provided that:

a. treatment occurs on an inpatient stay.

b. treatment occurs in an institution for the treatment of alcoholism approved by the Joint Commission on Accreditation of Hospitals,

c. treatment is ordered in writing by a Physician, for the entire length of time the patient is confined.

4.10 OUTPATIENT ALCOHOLISM AND DRUG ABUSE BENEFIT

Outpatient treatment of Alcoholism and Drug Abuse will be paid the same as any other illness.

4.11 INPATIENT MENTAL AND NERVOUS BENEFIT

Inpatient treatment of Mental and Nervous conditions will be treated the same as any other illness.

4.12 OUTPATIENT MENTAL AND NERVOUS BENEFIT

Outpatient treatment of mental and nervous conditions will be treated the same as any other illness.

4.13 HOME HEALTH CARE

Benefits will be paid, if a covered individual has covered charges for Home Health Care. The amount paid will be the fee charged, but not more than the maximum amount for a single visit. Benefits will not be paid for more than the maximum number of visits in any one calendar year.

Covered charges are those which meet all three of the following requirements:

1. They are medically necessary for the care of covered individual who is totally disabled and:

    a. the covered individual is under the direct care of a doctor;
    b. the plan treatment for the Home Health Care is established in writing by the attending doctor prior to the start of such treatment;
    c. the plan of treatment for Home Health Care is certified by the attending doctor at least once a month, and
    d. the covered individual is examined by the attending doctor once each 60 days.

2. They are for services provided by a home health agency.

   A "home health agency' means an agency which meets the following requirements:

   a. its primary services are those listed in 3. below;
   b. it is federally certified as a home health agency; and
   c. it is licensed, if licensing is required.

3. They are for one or more of the following, unless the charge is a covered charge under Major Medical Benefits:

   a. part-time or intermittent nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.);
   b. part-time or intermittent Home Health Aide services;
   c. social work performed by a licensed social worker;
   d. nutrition services performed by a licensed nutritionist;
   e. special meals.

Exclusions

No Home Health Care benefits will be paid for:

1. General housekeeping services: or
2. Services for custodial care: or

THE BENEFIT PERCENTAGE, THE MAXIMUM AMOUNT FOR A SINGLE VISIT AND THE MAXIMUM NUMBER OF VISITS ARE ALL SHOWN OF THE SCHEDULE OF BENEFITS.

4.14 HOSPICE BENEFITS

Major Medical Benefits will be paid if a covered individual has covered charges for services and supplies furnished directly by a hospice.

COVERED CHARGES

1. Room and board for confinement in a hospice or a hospice setting.
2. Services and supplies furnished by the hospice while the patient is confined in a hospice, hospice setting or at home.
3. Part-time nursing care by or under the supervision of a registered nurse (R.N.).
4. Home health aide services.
5. Nutrition Services.
6. Special meals.
7. Counseling services by a licensed social worker or a licensed pastoral counselor for patient's immediate family as follows:
    a. The benefit Percentage will be 50% for such services: and
    b. No more than a maximum of 15 visits will be covered for the patient's immediate family: and
    c. Such services will only be covered during the six-month period following the patient's death.

LIMITATIONS

Hospice Benefits will only be paid if the covered individual's attending doctor certifies that:

1. The covered individual is terminally ill: and
2. The covered individual is expected to die within six months or less.

Hospice benefits will be paid up to a maximum of 365 days during a covered individual's lifetime.

ANY COVERED CHARGE PAID UNDER HOSPICE BENEFITS WILL NOT BE CONSIDERED A COVERED CHARGE UNDER ANY OTHER BENEFIT IN THIS PLAN.

DEFINITIONS

"Hospice" means an agency that provides counseling and medical services and may provide room and board to a terminally ill individual and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.
2. It provides service 24 hours a day, 7 days a week.
3. It is under the direct supervision of a doctor.
4. It has a nurse coordinator who is a registered nurse (R.N.).
5. It has a social service coordinator who is licensed.
6. It is an agency that has as its primary purpose the provision of hospice services.
7. It has a full-time administrator.
8. It maintains written records of services provided to the patient.
9. It is licensed, if licensing is required.

SECTION V
ADDITIONAL PROVISIONS

5.01 PREGNANCY

Pregnancy is covered the same as any other illness for the participant or covered dependents as shown in the Schedule of Benefits.

5.02 MEDICARE

If a participant or covered dependent is age 65 and is covered by or is eligible to be covered by Medicare Parts A and B and the participant is an active employee, then this plan is primary.

5.03 WAITING PERIOD

The waiting period for coverage under this Plan is as shown in the Schedule of Benefits.

5.04 DEPENDENT CHILD MAXIMUM AGE

The maximum age for coverage under the Plan is stated under the Schedule of Benefits.

a. Regulations provide that a group health plan or insurer may base eligibility for dependent child coverage only in terms of the relationship between a child and participant, and may not deny or restrict coverage based on factors such as: financial dependency, residency, student status, employment or marital status.

b. The Plan does not require that the spouse of a dependent be covered, nor does it require that the dependent of a dependent be covered (which is a grandchild).

c. Regulations state that any covered child under age 26, whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll. Employees who wish to add dependents may do so whether they need to change their enrollment status from single or employee/spouse to a status that allows dependents, or if they were not previously in health coverage but wish to do so and add a dependent during the Open Enrollment period stated in the Plan.

5.05 TERMINATION OF COVERAGE - COBRA BENEFIT CONTINUATION

a. General. All eligible participants and dependents who would otherwise lose coverage under the Plan as a result of any qualifying event shall have the right to elect to continue coverage under the Plan if certain conditions are met. A "qualifying event" is any one of the following, which would otherwise result in loss of coverage to a participant or dependent:

i) The participant's death.

ii) The participant's termination of employment (other than for reasons of gross misconduct) or reduction of hours of employment.

iii) The participant's divorce or legal separation from his spouse.

iv) The participant's becoming entitled to benefits under Title XVIII of the Social Security Act.

v) A dependent who is the child of the participant ceasing to qualify as a dependent child under the applicable Plan provisions.

b. Notification Requirements. The Company must notify the Plan Administrator within thirty (30) days of the occurrence of any of the above qualifying events except the qualifying events specified in (a) (iii) or (v). For these qualifying events, the participant or dependent is responsible for notifying the Plan Administrator within sixty (60) days of their occurrence.

After receipt of notice of a qualifying event, the Plan Administrator shall notify the participant or affected dependent within fourteen (14) days of such person's right to elect continuation coverage under this Section 5.04.

c. Election Period. The election period shall begin not later than the date on which coverage terminates under the Plan due to any of the qualifying events listed above, shall be at least sixty (60) days duration, and shall end no earlier than sixty (60) days after the later of: (I) the date coverage terminates under the Plan due to any qualifying event listed above, or (ii) the date the Plan Administrator notifies the participant or covered dependent of his rights under the provision as described above.

Benefits must be identical to those under the Plan which are available to participants and covered dependents to whom any of the qualifying events listed above have not occurred.

d. Cost. The Company may require the participant and/or the covered dependent to pay for all or part of the cost for continuing his coverage not to exceed the maximum permissible percentage of the applicable premium determined pursuant to Section 4980B (f) (4) of the Internal Revenue Code of 1986, as amended. If the participant or covered dependent is required by the Company to pay the cost of continuing his coverage as described herein, payment must be made within forty-five (45) days from the date of election. Payments may be made in monthly installments if the participant or covered dependent so desires.

e. Duration of Coverage. Dependent spouses and children shall be eligible for continuation of coverage for up to thirty-six (36) months upon the occurrence of any of the following events:

i) The death of the participant.

ii) The divorce or legal separation of the participant from the covered dependent spouse.

iii) The participant becoming entitled to benefits under Title XVIII of the Social Security Act.

iv) The dependent child no longer being eligible for coverage as a dependent child as defined in the Plan.

v) The institution of proceedings under Medicare as described above.

The participant and covered dependents shall be eligible for continuation of coverage for up to eighteen (18) months upon the occurrence of any of the following events:

a. The participant's employment with the Company is terminated (except if due to the participant's gross misconduct).

b. The participant's working hours are reduced so as to render him ineligible for coverage as defined in the Plan.

Coverage will be extended to twenty-nine (29) months if the Participant, and/or the covered dependent is disabled at the time of qualifying event, and gives notice of the disability before the end of the eighteen (18) month period. Coverage will also be extended to thirty-six (36) months if another qualifying event occurs during the eighteen (18) month period following the termination of employment or reduction in working hours.

The continuation period will end when any of the following occur:

a. When the participant or dependent fails to make the required premium contribution to the Plan.

b. When the participant or covered dependent becomes entitled to benefits under Title XVIII of the Social Security Act.

c. When the participant or covered dependent becomes covered by any other group health plan.

d. When the dependent spouse remarries and becomes covered by a group health plan.

e. When the Company ceases to maintain a group health plan.

During the final one hundred eighty (180) days of the continuation period, the Company must provide the participant and covered dependents the opportunity to convert medical coverage to an individual health plan if such a conversion privilege is provided by the Plan.

5.07 ELECTIVE STERILIZATION

The Plan pays for certain Elective Sterilization procedures such as tubal ligations and vasectomies. These procedures shall be considered the same as any other illness only for:

a. covered participants;

b. spouses who are covered dependents.

Eligible expenses under this Plan shall not include reversals, or attempted reversals of these procedures.

5.08 WELL BABY CARE BENEFIT

Hospital charges incurred by a newborn during the first seven (7) days of life will be covered as charges of the baby. In addition, the following services will be covered during the same time period:

a. professional services;

b. circumcision;

5.09 EXTENSION OF BENEFITS

If a participant or dependent covered under the Plan is Totally Disabled when coverage terminates hereunder, except for reason of discontinuance of this Plan, benefits hereunder shall continue until the earliest of:

a. during the continuance of the Total Disability, up to ninety (90) days; but only for the condition which resulted in the period of total disability.

b. as soon as the person for whom benefits are continued is eligible for any other group or individual plan or coverage of insurance; or

c. termination of this Plan.

5.10 VETERANS ADMINISTRATION/DEPT. OF DEFENSE CHARGES

The Plan shall be liable for the reasonable cost of services and supplies which are billed, pursuant to Federal Law, by hospital facilities maintained by the Veterans Administration and the Department of Defense of the United States of America, provided that:

a. the expenses are incurred by a participant or covered dependent while covered under the Plan; and

b. the expenses are incurred for services and supplies which are covered under the Plan; and

c. the expenses are not incurred for illness or injury, which occurs during or arises from service in the Armed Forces of the United States of America.

All Plan provisions, requirements and limitations shall apply to charges billed by the Veterans Administration and the Department of Defense.

5.11 PROHIBITION OF RECISIONS

Group health plans may not rescind coverage once a participant is covered under the plan.

SECTION VI
GENERAL EXCLUSIONS AND LIMITATIONS

6.01 The following are excluded under the Plan:

a. Charges are not for the care or treatment of an accident or illness except as specifically provided for in this Plan.

b. Cosmetic surgery or related hospital admissions, unless made necessary:

i) by an accidental injury while covered hereunder; provided such coverage is received within twelve (12) months of the injury.

ii) by congenital abnormalities while less than twelve (12) years old, provided that it is not medically necessary to delay the procedure, for conditions resulting from injuries or traumatic scars;

iii) for reconstructive surgery for the prompt treatment of a diseased condition while covered hereunder.

c. Charges for or in connection with treatment of teeth or periodontium or treatment of periodontal or periapical disease of any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure, except for oral surgery for repair of accidental injury to sound, natural teeth while covered under this Plan, or as provided herein.

d. Medical treatment of the Temporomandibular Joint (TMJ) and other jaw disorders and services directly attributable to the TMJ dysfunction will be considered dental expenses and are limited to the maximum benefit payment stated in the Schedule of Benefits. Direct treatment to the teeth or periodontium shall be considered dental services and are excluded from the medical portion of this Plan.

e. For hospital care and services rendered after the patient has been discharged from the hospital by the attending physician.

f. Services covered by or for which the participant is entitled to benefits under any Worker's Compensation or similar law.

g. Services in a hospital owned or operated by the United States government or any government outside the United States in which the participant or dependent is entitled to receive benefits except as provided herein.

h. Charges that the participant is not legally required to pay for or for charges which would not have been made if this coverage had not existed.

i. Charges that are reimbursed, or that could be reimbursed by any public program.

j. Expenses covered by medical coverage provided through "no fault" auto coverage.

k. Treatment made necessary by war, declared or undecided or undeclared, or any act of war. An act of terrorism will not be considered an act of war, declared or undeclared.

l. Eyeglasses, contacts, eye refractions, hearing aids, or examinations for prescriptions or fitting of eyeglasses, contacts, hearing aids or charges for radial keratotomy except as provided for herein.

m. Routine services such as, but not limited to, routine physical exams, premarital exams and newborn immunizations, unless specifically provided for herein.

n. Routine pediatric care of well newborns, unless specifically provided for herein.

o. Travel outside of the United States, whether or not recommended by a physician, if such travel is for the sole purpose of obtaining services.

p. Sanataria or rest cures.

q. Custodial care, which is care with the primary purpose of meeting personal rather than medical needs and which is provided by persons with no special medical skills or training. Such care includes, but is not limited to: helping a patient walk, getting in or out of bed, and taking normally self-administered medicine.

r. Treatment or services provided by anyone other than a physician as defined herein.

s. Experimental or generally non-accepted medical practices.

t. Birth control medications or devices, except as provided herein.

u. Hospital services performed in a facility other than as defined herein.

v. Charges in excess of the reasonable and customary rate and/or are not appropriate in the treatment of the diagnosed illness or injury.

w. Services and/or supplies for recreational or educational therapy or forms of non-medical self-care or self-help training, and any related diagnostic testing.

x. Organ transplant surgeries except for transplant surgery, which is not considered experimental in nature. Covered expenses of the donor will be limited to a maximum payment of $3,000 unless the donor is covered under this plan.

y. Services and/or supplies for injuries arising from suicide, attempted suicide or intentional self-inflicted bodily injury or illness unless it can be demonstrated that the injury or illness resulted from a medical condtion (physical and mental) or from domestic violence.

z. Air conditioners, purifiers, humidifiers, heating pads, arch supports and hot water bottles.

aa. Treatment of obesity or for weight reduction, except for surgery necessitated by a specifically identifiable medical condition of morbid obesity.

bb. Services and/or supplies provided by a Veterans' Administration Hospital for outpatient care unless determined that emergency care at such facility was imperative.

cc. Services and/or supplies furnished during periods when the participant or covered dependent is temporarily absent from the hospital.

dd. Services and/or supplies related to sex transformations or sexual dysfunctions or inadequacies.

ee. Exercise equipment and nutritional supplements.

ff. Marital, family or other counseling or training services, except as provided herein.

gg. Services rendered or billed for or by a school or halfway house or a member of its staff.

hh. Milieu therapy; any confinement in an institution primarily to change one's environment.

ii. Services and/or supplies made by a physician, nurse or other medical practitioner who resides in the household of the participant or covered dependent or who is related to the participant or covered dependent.

jj. Hospital admissions which begin on Friday or Saturday; but the hospital expenses for those days only if surgery does not occur on either of those days and the admission is not an emergency. "Emergency" means that the admission cannot be scheduled at the convenience of the patient or the physician without endangering the patient's health or causing the patient to become permanently disabled.

kk. Benefits will be limited if the covered person does not comply with Precertification

ll. Illness or injury caused or contributed to, by engagement in an illegal occupation or commission or attempt to commit a felony.

mm. Artificial insemination

nn. Radial keratotomy or refractive surgery.

oo. Sterilization reversal or infertility treatment, unless specifically referenced in the Schedule of Benefits, "Treatment of Infertility" means the use of methods which do not correct the ability to conceive, but create the conditions for the individual to conceive by stimulating the natural reproductive system or by implementation. Methods used to correct the inability to conceive are not subject to this limitation.

pp. Elective abortions which are not medically necessary to save the life of the mother.

qq. Preventive inoculations that are not administered in the treatment of an illness, or disease or condition.

SECTION VII

DEFINITIONS

7.01 AMBULATORY SURGICAL CENTER

The term "Ambulatory Surgical Center" means an institution or facility, either free standing or as part of a hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted and discharged within a twenty-four (24) hour period.

7.02 BENEFIT PERIOD

The benefit period is a calendar year, beginning on January 1, and ending December 31 of that year.

7.03 CONVALESCENT FACILITY

An institution or a distinct part of an institution meeting all of the following tests:

It is licensed to provide and is engaged in providing, on an inpatient basis, for persons convalescing from injury or disease, professional nursing services rendered by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered graduate nurse, physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities. Its services are provided for compensation from its patients and which patients are under the full-time supervision of a physician or registered graduate nurse (R.N.).

It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered graduate nurse (R.N.).

It maintains a complete medical record of each patient.

It has an effective utilization review plan.

It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, the mentally handicapped, custodial or educational care, or care of mental disorders.

7.04 DEPENDENT

The term dependent means the spouse of the participant, if not divorced, and unmarried or married dependent children who are a resident of the same country as the participant and are the participant's:

a. natural children;
b. stepchildren and foster children who qualify as the participant's dependents for federal income tax purposes; or
c. legally adopted children, or foster children.
d. adult dependent children can remain on the plan even if they are: married, not living with the insured, attending school, not financially dependent on the insured, eligible to enroll in their employers plan.

Such individuals must depend upon the participant for support. An application for coverage hereunder must be submitted to the Plan as required. Such child shall remain a Dependent hereunder until: a) marriage; or b) when he attains the age specified in the Schedule of Benefits. In the event a child who is a Dependent as defined herein is incapable of self-sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon the participant for support and maintenance beginning prior to the end of the calendar year in which such child attains the age specified in the Schedule of Benefits, coverage will continue as a dependent until the earliest of the following:

a. the participant, for any reason, discontinues his coverage hereunder;

b. the participant is no longer considered an eligible participant;

c. the Plan is canceled, or

d. the disability no longer exists as determined by the Plan. Such disability requirements will also include the provisions established Public Law 110-381 also referred to as Michelle's Law. Coverage will continue for an eligible dependent child requiring a medically necessary leave of absence from a post-secondary educational institution after receiving a Treating physician's certification. Coverage will continue until the earlier of:
   - One (1) year after the 1st day of medically necessary leave or,
   - The date dependent coverage otherwise would end regardless of leave.

Satisfactory evidence of such disability and dependence may be required by the Plan. Such evidence must be received within 120 days after the end of the calendar year in which the maximum age is attained.

7.05 DONOR

A donor is the person who provides the organ for the recipient in connection with organ transplant surgery. A donor may or may not be a participant or covered dependent covered under the provisions of this Plan.

7.06 HOSPITAL

An institution which, for compensation from its patients and on an inpatient basis, is primarily engaged in providing diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and ill persons by or under the supervision of a staff of physicians who are duly licensed to practice medicine, and which continuously provides twenty-four (24) hour a day nursing services by registered graduate nurses. It is not, other than incidentally, a place for rest or for the aged. For services covered by this Plan and for no other purpose, inpatient services for treatment of mental illness or substance abuse that are provided by a community mental health center or by any psychiatric hospital licensed by the State Board of Health of the Department of Mental Health will be considered services rendered in a hospital as defined herein.

7.07 ILLNESS

The term illness means an illness causing loss while this Plan is in force as to the covered person whose illness is the basis of the claim. Illness shall also be deemed to include disability caused or contributed to pregnancy, miscarriage, childbirth and recovery therefrom. It shall only mean illness or disease, which requires treatment by a physician.

7.08 INCURRED CHARGE

The charge for a service or supply is considered to be incurred on the date it is furnished. In the absence of due proof to the contrary when a single charge is made for a series of services, each service will be considered to bear a pro rata portion of the charge.

7.09 INJURY

The term injury shall mean only bodily injury caused by an accident while the Plan is in force as to the covered person whose injury is the basis of the claim. Injury shall mean only those injuries, which require treatment by a physician. A hernia shall be considered an illness, rather than an injury.

7.10 MEDICALLY NECESSARY

Medical services and/or supplies which are absolutely needed and essential to treat an illness or injury of a covered participant or dependent while covered by this Plan. Such treatment must be appropriate and consistent with the diagnosis, and in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

7.11 MEDICARE

The programs established by Title XVIII of the U.S. Social Security Act as amended and as may be amended, entitled Health Insurance for the Aged Act, and which includes Part A - Hospital Insurance Benefits for the Aged; and Part B - Supplementary Medical Insurance Benefits for the Aged.

7.12 PARTICIPANT

An employee of the Company who meets the eligibility requirements for coverage under the Plan.

7.13 PHYSICIAN

The term physician means a doctor of medicine or doctor of osteopathy who is legally qualified and acting within the scope of their license or state law to practice medicine, surgery, or obstetrics at the time and place service is rendered. For services covered by this Plan and for no other purpose, doctors of dental surgery, doctors of dental medicine, doctors of podiatry or surgical chiropody, optometrists, chiropractors, nurse practitioners, midwives, physicians assistant and health service providers in psychology are deemed to be physicians when acting within the scope of their license for services covered by this Plan. Registered Physical Therapists, and Registered Speech Therapists will be covered under this definition as prescribed and supervised by a Medical Doctor (M.D.).

7.14 PLAN ADMINISTRATOR

The person, group or organization responsible for the day to day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan connected services. The Plan Administrator is the Company.

7.15 PLAN DOCUMENT

The term "Plan Document" whenever used herein shall without qualification mean the Plan and the Description of Benefits Appendix.

7.16 PLAN SUPERVISOR

The person or group providing administrative services to the Company in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it.

7.17 PLAN YEAR

The term "Plan Year" means an annual period beginning on the effective date of this Plan and ending twelve (12) calendar months thereafter or upon termination of the Plan, whichever occurs earliest.

7.18 PREGNANCY

The term "pregnancy" means the condition of being pregnant and all conditions and/or complications resulting therefrom. Pregnancy is covered by the Plan in the same way as any other illness of participants and covered dependents as stated in the Schedule of Benefits.

7.19 REASONABLE AND CUSTOMARY

A reasonable and customary charge is the usual charge made by a physician or supplier for services, medicines, or supplies and shall not exceed the general level of charges made by others rendering or furnishing such services, medicines or supplies within the area in which the charge is incurred for illness or injuries comparable in the severity and nature to the illness or injury being treated. The term "area" as it applies to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of level charges.

7.20 RECIPIENT

The recipient is the person who receives the organ for transplant from the organ donor. The recipient shall be a participant or covered dependent covered under the provisions of this Plan. Only those organ transplants not considered experimental in nature are eligible for coverage under this Plan.

7.21 ROOM AND BOARD CHARGES

The institution's charges for room and board and its charges for other necessary institutional services and supplies, made regularly at a daily or weekly rate as a condition of occupancy of the type of accommodations occupied.

7.22 SEMI-PRIVATE RATE

The daily room and board charge which an institution applies to the greatest number of beds in its semi-private rooms containing two (2) or more beds. If the institution has no semi-private rooms, the semi-private rate will be the daily room and board rate most commonly charged for semi-private rooms with two or more beds by similar institutions in the area. The term "area" means a city, a county of any greater area necessary to obtain a representative cross section of similar institutions.

7.23 SUCCESSIVE CONFINEMENTS

Successive confinements will be considered a continuation of a prior confinement unless they are separate by at least sixty (60) days.

7.24 SURGICAL PROCEDURE

A surgical procedures means cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, paracentesis, applying plaster casts, administering pneumothorax, endoscopy, injecting sclerosing solution, arthroscopic procedures or urethral dilation.

7.25 TOTAL DISABILITY

The terms total disability and totally disabled mean:

a. participant - his inability to engage, as a result of accident or illness, in his normal occupation with the Company,
b. dependent - his inability to perform the usual and customary duties or activities of a person in good health and of the same age and sex.

7.26 TREATMENT

Any service or supply used to evaluate, diagnose or remedy a condition of a participant or his covered dependents.

7.27 WAITING PERIOD

The period of time a participant must be actively at work, as defined in the Schedule of Benefits prior to becoming eligible for coverage under the Plan.

7.28 OUTPATIENT DIALYSIS

Benefits provided under this Plan for treatment received in connection with Outpatient Dialysis are subject to the following provisions:

The Plan provides an alternative basis for payment of claims associated with dialysis-related services and products provided on an outpatient basis (Outpatient Dialysis). This alternative basis may be applied to claims by any healthcare provider, regardless of the healthcare provider's participation in the Preferred Provider Organization (PPO).

All eligible employees and their dependents requiring Outpatient Dialysis are subject to cost containment review, negotiation and/or other related administrative services which the Plan Administrator may elect to apply in the exercise of the Plan Administrator's discretion.

The Plan shall pay no more than the Usual and Reasonable Charge for covered services and/or supplies incurred in connection with Outpatient Dialysis, after deduction for all amounts payable by coinsurance or deductibles. The Plan Administrator shall determine the benefits based on the Usual and Reasonable Charge. The Plan Administrator may pay or reimburse charges greater than the Usual and Reasonable Charge based upon factors concerning the nature and severity of the condition being treated, geographic and market considerations and provider availability, in the exercise of the Plan Administrator's discretion. All charges must be billed in accordance with NCCI (National Correct Coding Initiative).

For the purposes of this provision, the following definitions shall apply:

Determination of the Usual and Reasonable Charge will consider the prevailing payment parameters and correct coding as set forth by NCCI and CMS (Centers for Medicare and Medicaid Services) for End Stage Renal Disease Dialysis.

SECTION VIII
GENERAL INFORMATION

8.01 CONDITIONS PRECEDENT TO THE PAYMENT OF BENEFITS

The participant or dependent shall present the "Plan" identification card upon admission to a hospital or upon receiving service from a physician.

Written proof of the nature and extent of service performed by a physician shall be furnished to the Plan Supervisor within sixty (60) days after the service was rendered. Forms are available through the Plan Supervisor, and are required along with an itemized statement with a diagnosis, the participant's name and Social Security number and the name of the Plan Administrator.

The participant and all dependents shall agree that in order to receive benefits hereunder, any physician, nurse, hospital or other providers of service, having rendered service or being in possession of information or records relating thereto, is authorized and directed to furnish the Plan Supervisor, at any time, upon request, any and all such information and records, or copies thereof.

8.02 PRIVILEGES AS TO DEPENDENTS

The participant shall have the privileges of adding or withdrawing the name or names of any dependent(s) to or from this coverage, as permitted by the Plan, by submitting to the Plan Administrator an application for reclassification, furnished by the Plan Supervisor. Each dependent added to the coverage shall be subject to all conditions and limitations contained in this Plan.

8.03 APPLICATION AND IDENTIFICATION CARD

To obtain coverage, an eligible participant must complete and deliver to the Plan Administrator an application on a form supplied by the Plan Supervisor.

Acceptance of this application will be evidenced by the delivery of an identification card showing the Participant's name, by the Plan Supervisor to the Plan Administrator.

8.04 SUMMARY PLAN DESCRIPTION

The Plan Supervisor will assist the Plan Administrator prepare and deliver to the participants an individual benefit booklet setting forth a statement of the benefits to which they are entitled, and such limitations or requirements in the Plan Document as may pertain to the participant or his dependents.

8.05 CANCELLATION

A participant may cancel his coverage by giving written notice to the Plan Administrator who will notify the Plan Supervisor. Such coverage will terminate on the date of the plan month on which such termination is requested.

In the event of the cancellation of this Plan, all participants and dependents coverage shall cease automatically without notice and these participants and dependents shall not be entitled to further coverage or benefits thereafter.

Upon termination of this Plan, all claims incurred prior to termination of this Plan, but not submitted to the Plan Supervisor within ninety (90) days of the effective date of termination of this Plan, will be excluded from any benefit consideration.

8.06 ASSIGNMENT OF PAYMENT

The Plan will pay any benefits accruing under this Plan to the participant unless the participant shall assign benefits to a hospital, physician or other provider of service furnishing the services for which benefits are provided herein. No assignment, however, shall be binding on the Plan unless the Plan Supervisor is notified in writing of such assignment prior to payment hereunder.

8.07 NOTICE

Any notice given under this Plan shall be sufficient, if given to the Plan Administrator when addressed to it at its office; if given to the Plan Supervisor, when addressed to it at its home office; or if given to a participant, when addressed to the participant at his address as it appears on the records of the Plan Supervisor in the care of the Plan Administrator.

8.08 COORDINATION OF BENEFITS

a) Definitions:

i) The term "allowable expense" shall mean the amount of expenses, at least a portion of which is paid under at least one of any multiple plans covering the person for whom the claim is made.

ii) The term "order of benefit determination" shall mean the method for ascertaining the order in which the Plan renders payment hereunder. The principle applies when another plan has a coordination of benefits provision.

b) Order of Benefit Determination Rules in Indiana

When two group plans cover an employee (or an employee's dependents) and one of the plans does not have Coordination Of Benefits (COB) provisions, the plan without COB provisions pays its benefits first. When both plans have COB provisions, the rules below apply:

Employee/Dependent: The Plan covering the person as an employee pays benefits first. The plan covering the person as a dependent pays benefits second.

Dependent Children of Parents Not Separated or Divorced:

Birthday Rule: The plans covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan, which has covered the parent longer, pays first. The plan, which covered the other parent for a shorter time, pays second. A person's year of birth is not relevant in applying this rule.

However, if one coordinating plan uses the birthday rule and the other uses the male/female rule, both plans will follow the male/female rule. This fall back provision avoids the possibility that both plans will be primary or that both plans will be secondary.

Dependent Children of Separated or Divorced Parents: When parents are separated or divorced, neither the male/female nor the birthday rules apply. Instead:

(a) The plan of the parent with custody pays first;

(b) The plan of the spouse of the parent with custody
(i.e., the step-parent) pays second; and

(c) The plan of the parent without custody pays last.

However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses and the insurer or other entity obliged to pay or provide the benefits of that parent's plan has actual knowledge of those terms, that plan pays first. If any benefits are actually paid or provided before that entity has actual knowledge of those terms, this "court decree" rule is not applicable during the remainder of the plan or policy year.

Active/Inactive Employee: The plan covering the person as an employee (or as that person's dependent) who is not laid-off or retired pay's benefits first. The plan covering that person as a laid-off or retired employee (or as that person's dependent) pays benefits second. If both plans do not agree on the order of benefits, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This fall back provision prevents both plans from being secondary.

Longer/Shorter: If none of the aforementioned rules determines the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

8.09 SUBROGATION

If this Plan provides for Injury, Illness or other loss (the Injury) sustained by the Covered Person (the Injured Party), this Plan will be subrogated to all rights of recovery the Injured Party, his heirs, guardians, executors or other representatives may have arising from the Injury. This Plan's subrogation rights include, but are not limited to, a right of recovery against any person, insurance company or other entity that is in any way responsible for providing compensation or other payment as a result of the Injury or Illness or other loss. This Plan's subrogation rights include a right of recovery under not fault, personal injury protection, Medpay, financial responsibility uninsured motorist, uninsured motorist insurance coverages or medical reimbursement insurance, specific risk insurance, "school" or "team" insurance, workers' compensation and third party liability.

The injured Party and any person acting on his behalf may be requested to provide this Plan with information this Plan believes necessary to protect its right of subrogation. If such a request is made, the Injured Party and any person acting on his behalf are obligated to provide this Plan with such information and to do nothing to prejudice this Plan's right of subrogation.

Notification of this Plan's right of subrogation is sufficient to protect this Plan's subrogation interest and the initiation of or intervention in any legal action shall not be required or necessary to establish this Plan's right of subrogation. This Plan shall be entitled to assert a lien against third parties, insurers, attorneys and any other persons when and as necessary in order to protect the rights of the beneficiaries of this Plan or Plan assets.

The amount of this Plan's subrogation interest shall be deducted first from any recovery by or on behalf of the Injured Party or any person acting on his behalf. This Plan shall not be responsible for expenses or fees incurred in connection with any other persons when and as necessary in order to protect the rights of the beneficiaries of this Plan or Plan assets.

The amount of this Plan's subrogation interest shall be deducted first from any recovery by or on behalf of the Injured Party or any person acting on his behalf. This Plan shall not be responsible for expenses or fees incurred in connection with any recovery unless this Plan shall have agreed in writing to pay a portion of those expenses or fees. This Plan reserves the right to initiate an independent action in the name of the Injured Party or his representative to recover its subrogation interest.

8.10 MEDICARE

a) Definitions
MEDICARE - as used in this section shall mean title XVIII (Health Insurance for the Aged) of the United States Social Security Act, as added to by the Social Security Amendments of 1965, the Tax Equity and Fiscal Responsibility Act of 1982, or as later amended.

PERSON - as used in this section means a person who is eligible for benefits as a participant in an eligible class of this Plan and who is or could be covered by Medicare Parts A and B, whether or not actually enrolled.

ELIGIBLE EXPENSES - as used in this section with respect to services, supplies and treatments shall mean the lesser of the total amount of charges allowable by Medicare, whether enrolled or not and the total eligible charges allowable under this Plan exclusive of coinsurance and deductible.

ORDER OF BENEFITS DETERMINATION - as used in this section shall mean the order in which Medicare benefits are paid, in relation to the benefits of this Plan.

b. Determination of Benefits
THE TOTAL BENEFITS OF THIS PLAN SHALL BE DETERMINED AS FOLLOWS:

i) If a participant is covered by or is eligible to be covered by Medicare Parts A and/or B and the participant is an active employee between the ages of 65 and 70, then he may elect to be covered by Medicare or this Plan. The election must be in writing and submitted to the Plan Supervisor. If the active participant or his non-working spouse participates in this Plan, then Medicare will supplement payments of this Plan.

ii) For covered persons who are not active employees between the ages of 65 and 70, and that are eligible for Medicare by reason of age alone, the following formula as shown in the Schedule of Benefits shall be used in determining the total payable under this Plan as primary payor during EACH claim submission:

COORDINATION - The regular Coordination of Benefits provision of this Plan applies in relation to the amount Medicare pays as secondary payor.

iii) For persons eligible for Medicare either entirely or in part by reason other than age, the following provisions shall apply:

For persons eligible for Medicare by reason of End Stage Renal Disease. After becoming eligible for Medicare due to End Stage Renal Disease, benefits of this Plan shall be primary as they relate to the Order of Benefits Determination during the initial thirty (30) month period. After thirty (30) months from the date the person first becomes eligible for Medicare due to End Stage Renal Disease, Medicare becomes primary and the Plan secondary.

8.11 FACILITY OF PAYMENT

If, in the opinion of the Plan Supervisor, a valid release cannot be rendered for the payment of any benefit payable under this Plan, the Plan Supervisor may, at its option, make such payment to the
individuals who have, in the Plan Supervisor's opinion, assumed the care and principal support of the covered person and are therefore equitably entitled thereto. In the event of the death of the covered person before all benefits payments due him have been made, the Plan Supervisor may, at its sole discretion and option, honor benefit assignments, if any, prior to the death of such covered person.

Any payment made by the Plan Supervisor in accordance with the above provisions shall fully discharge the Plan Supervisor to the extent of such payment.

8.12 MISREPRESENTATION

Any material misrepresentation on the part of the Plan Administrator or the participant in making application for coverage, or any application for reclassification thereof, or for service thereunder shall render the coverage null and void.

8.13 INADVERTENT ERROR

Inadvertent effort by the Plan Administrator in the keeping of records or the transmission of participants' applications shall not deprive any participant or dependent of benefits otherwise due, provided that such inadvertent error is brought to the attention of the Plan Administrator within ninety (90) days after it was made.

8.14 FREE CHOICE OF PHYSICIAN

The participant and dependents shall have free choice of any licensed Physician or surgeon, and the Physician-patient relationship shall be maintained.

8.15 NOT LIABLE FOR ACTS OF HOSPITALS OR PHYSICIANS

The Company and Plan are not responsible for the quality of care, services, products or medications a participant or dependent receives from any person. Nothing contained herein shall confer upon a participant or dependent any claim, right, or cause of action, either at law or at equity, against the Company or the Plan for the acts or omissions to act of any Hospital, facility or Ambulatory Care Center, or for the acts or omissions of a Physician, nurse or health care provider from whom he receives services under this Plan.

8.16 APPLICABLE LAW

It is the intent of the parties to this Plan that the provisions herein shall be subject to and interpreted by the law of the State of Indiana to the extent not preempted by federal law.

8.17 RIGHT OF RECOVERY

Whenever payments have been made by the Plan Supervisor in excess of the maximum amount of payment necessary that time to satisfy the intent of this Plan, the Plan Supervisor shall have the right to recover such payments, to the extent of such excess, from among one or more of the following as the Plan Supervisor shall determine: any persons to or for, or with respect to whom such payments were made, and/or any insurance companies and other organizations.

8.18 PLAN IS NOT A CONTRACT

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

8.19 FIDUCIARY OPERATION

Each fiduciary shall discharge his duties with respect to the Plan solely in the interest of the participants and beneficiaries are: (1) for the exclusive purposes of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the Plan, (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims, and (3) in accordance with the documents and instruments governing the Plan to the extent that they are consistent with the provisions of the Employee Retirement Income Security Act of 1974.

8.20 FUNDING

If contributions are required of participants or dependents covered under this Plan, the Plan Administrator will maintain a Trust for the receipt of money and property to fund the Plan, for the management and investment of such funds and for the payment of claims and expenses from such funds. The terms of the Trust hereby are incorporated by the reference as of the effective date of the Trust, as a part of the Plan.

The Plan Administrator shall deliver from time to time to the Trust such amounts of money and property as shall be necessary to provide the Trust with sufficient funds to pay all claims and reasonable expenses of administering the Plan as the same shall be due and payable. The Plan Administrator may provide for all or any part of such funding by insurance issued by a company duly qualified to issue insurance for such purpose in the state of situs, and may pay the premiums thereof directly or by funds deposited in the Trust. All funds received by the Trust and all earnings of the Trust shall be applied toward the payment of claims and reasonable expenses of administration of the Plan except to the extent otherwise provided by the Plan Documents. The Plan Administrator may appoint an investment manager or managers to manage (including the power to acquire and dispose of) any assets of the Plan.

Any fiduciary, participant, agent, representative or other person performing services to or for the Plan or Trust shall be entitled to reasonable compensation for services rendered, unless such person is the Plan Administrator, and for reimbursement of expenses properly and actually incurred.

If contributions are not required of participants or dependents covered under this Plan, or if said contributions need not be deposited in a trust by virtue of federal regulations, rulings or policy, the Plan Administrator may elect not to maintain a Trust.

8.21 RIGHTS TO PARTICIPANTS

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office all plan documents, including insurance contracts, bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports and Plan Descriptions.

Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report upon request.

File a suit in a federal court, if any materials requested are not received within thirty (30) days of the participant's request, unless the materials were not sent because of matters beyond the control of the Plan Administrator. The court may require the Plan Administrator to pay up to $110. for each day's delay until the materials are received.

In addition to creating rights for plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the benefit plan. These persons are referred to as "Fiduciaries" in the law. Fiduciaries must act solely in the interest of the plan participants and they must exercise prudence in the performance of their plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the plan.

Your employer may not fire you or discriminate against you to prevent you from obtaining a benefit or exercising your rights under ERISA.

If you are improperly denied a benefit in full or in part, you have a right to file suit in a federal or state court. If plan fiduciaries are misusing the plan's money, you have a right to file suit in a federal court or request assistance from the U.S. Department of Labor. If you are successful in your lawsuit, the court may, if it so decides, require the other party to pay your legal costs, including the attorney's fees.

If you have any questions about this statement of your rights under ERISA, you should contact the Plan Administrator or the nearest Area Office of the U.S. Labor-Management Service Administration, Department of Labor, Pension and Welfare Benefits Administration or the Division of Technical Assistance and Inquires, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

8.22 **FAMILY MEDICAL LEAVE ACT CONTINUED COVERAGE**

All Participants covered under the Plan who are eligible for a leave of absence under the Family Medical Leave Act of 1993 ("FMLA") shall have the right to continue coverage under the Plan for the term of the leave of absence under the same terms, conditions and coverage as enjoyed by all other Participants.

If the Plan requires a contribution from the Participant for normal coverage, those contributions must be paid by the Participant during the term of the leave of absence in order for coverage under the Plan to continue.

If the leave of absence is a paid leave, normal contributions will be deducted from those payments. If the leave of absence is not a paid leave, the Participant must pay the contribution to the Plan, through the Company as the Plan Administrator, at the same time that contributions are normally taken from the Company payroll. If a contribution is not made within 30 says of such date, coverage under the Plan will end for the Participant and all covered dependents at the end of 30 days. All eligible claims, which are incurred during the 30 days, will still be considered as eligible by the Plan. The Company may withhold a delinquent contribution from any amount due the Participant or may bring a legal action to recover the contribution if not paid by the Participant.

If a Participant returns to employment during or at the end of the FMLA leave of absence and during the leave the Participant's coverage under the Plan has ended for any reason, the Participant will be allowed to re-enter the Plan as of the date that the Participant returns to work. The Participant and those dependents who were previously covered by the Plan will not be subject to a new waiting period or be required to submit Proof of Good Health. Coverage for new entrants at the time that the Participant returns to work will be governed by the terms of the Plan.

The Company may recover its contribution to the Plan for a Participant who is on an unpaid FMLA leave of absence if the Participant fails to return to work for at least 30 days after the FMLA leave has been exhausted or expires, unless the reason the Participant does not return to work is due to:

(1) The continuation, recurrence, or onset of a serious health condition which would entitle the Participant to leave under the FMLA; or
(2) Other circumstances beyond the participant's control.

The Company may recover its contribution from any sums due the Participant provided such deductions do not violate applicable Federal or State wage payment or other laws. The Company may also bring legal action against the Participant to recover its share of the contribution.

If the Participant elects or is required to substitute normal Company paid leave (vacation, sick days, personal days, etc.) for part or all of the FMLA leave the Company may not recover its contribution for the period of the leave that is covered by the normal Company paid leave.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If an employee, who is a Covered Person and who has a child or children, becomes divorced and the child, or children, were not Covered Persons at the time of the divorce, they may become covered under the Plan. However, in order for the child to become covered the Plan Administrator must receive, from the court, which has jurisdiction over the divorce, a Qualified Medical Child Support Order (QMCSO). The QMCSO must be in the proper form to be a valid QMCSO.

To be a valid QMCSO the court order must include the following information:

1. The name and last known mailing address of the Covered Person through whom the child or children will receive benefits.

2. The name and last known mailing address of each child who will be covered by the Plan.

3. The name of the Plan the child or children will be covered by.

4. A reasonable description of the type of coverage to be provided by the Plan or the manner in which such type of coverage is to be determined.

5. The period to which such order applies, and

6. The Judge, Commissioner or Magistrate who is presiding over the divorce must sign the QMCSO.

The QMCSO may not require the Plan to provide any type of form of benefit, or any benefit option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act.

If the QMSCO does not contain the proper information benefits will not be extended until a QMCSO, which meets the information requirements, is presented to the Plan Administrator. However, if a QMSCO is returned to the participant for lack of information or for provision of benefit reasons there will be an opportunity to provide a corrected order. However, a corrected order must be provided within ninety days of the initial order or coverage will be denied. If a corrected order is timely provided coverage will begin on the date of the earliest order.

Under a QMSCO the fact that the child is eligible for, is entitled to, or is provided benefits under Title XIX of the Social Security Act, will not affect the child or children's receipt of benefits under the QMSCO.

No eligibility for insurance or evidence of good health are required for coverage of a child using a QMSCO.

ADOPTED CHILDREN

Children who are placed with a Covered Person for adoption are eligible for coverage at the time they are placed. The Plan may not restrict coverage under the Plan of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption.

Definitions: For purposes of this section -

a) Child: The term "child" means, in connection with any adoption, or placement for adoption, of the child, an individual who has not attained age 18 as of the date of such adoption or placement for adoption.

b) Placement for Adoption: The term "placement" or being "placed" for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

8.23 NEWBORN AND MOTHER HEALTH PROTECTION ACT OF 1996

The Plan will at all times comply with the terms of the Newborn and Mother Health Protection Act of 1996. The Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or to less than 96 hours following a cesarean section. The plan will also not require that provider obtain authorization from the Plan for the hospital stay of the mother or newborn child for the first 48 hours following a normal vaginal delivery or for the first 96 hours following a cesarean section.

8.24 WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Department of Labor passed the Mastectomy Provision. The Omnibus Appropriations Bill, signed into law on October 21, 1998, amended ERISA and the Public Health Service Act by adding a new section that requires group health plans providing medical and surgical benefits with respect to a mastectomy to provide the following coverage to a plan participant who elects breast reconstruction in connection with such mastectomy:

1) reconstruction of the breast on which the mastectomy has been performed;
2) surgery and reconstruction of the other breast to produce symmetrical appearance;
3) coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage will be treated the same as any other illness and will be subject to the deductible and coinsurance amounts.

8.25 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is a new federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The new law prevents discrimination from health insurers and employers.

SECTION IX

PRESCRIPTION DRUG BENEFITS

INCORPORATION OF MEDICAL PROVISIONS

The provisions of the Medical Plan are incorporated by reference in the prescription drug plan except where inconsistent with provisions of the prescription drug plan.

WHAT IS COVERED

Benefits are payable if a covered person incurs charges for prescription drugs dispensed by order of a physician.

HOW MUCH

The Plan will pay for each separate prescription drug order made by a pharmacy licensed to fill prescription orders as shown in the Schedule of Benefits. This will also apply to each authorized refill.

> **NOTE:** In no event will the coordination of benefits provision of this Plan apply to the payment of prescription drug benefits.

LIMITATION ON QUANTITY

The maximum amount or quantity of prescription drugs covered per co-payment is a thirty (30) day supply or a one-hundred (100) unit dosage for items on the maintenance drug list.

When using the mail service prescription drug program, the maximum amount or quantity of prescription drugs covered per co-payment is a ninety (90) day supply.

HOW TO FILE A CLAIM

If your prescription is filled by a provider participating in this prescription drug benefit Plan, present your identification card and pay any applicable co-payment amount.

If your prescription is filled by any other provider or if your prescription is filled before you receive your identification card, pay the provider the cost of the prescription. If your prescription charge exceeds the co-payment amount, submit a completed reimbursement claim form to the prescription drug administrator.

If your card is lost or damaged, report it immediately to your employer. Reimbursement claim forms may be obtained from your employer.

NOTE: All prescription drug charges must be filed in accordance with the above procedure within ninety (90) days of the date of service in order for the claim to be considered an allowable expense under the Plan.

PRESCRIPTION DRUG EXCLUSIONS

Benefit coverage does not include charges that are not specifically included in the definition of "Prescription Drug"; non-legend, patent or proprietary medication or medication not requiring a prescription (except insulin); any drug labeled, "Caution – Limited by Federal Law to Investigational use" or experimental drugs even though a charge is made to the individual.

SECTION X

PREFERRED PROVIDER ORGANIZATION (PPO)

A Preferred Provider Organization (PPO) is a local area network of medical care providers (hospitals and physicians) who will offer quality care and will accept lower reimbursement for services provided. Your Medical Plan will pay an increased benefit for services provided by PPO providers.

WHAT ADVANTAGES DOES THE PPO OFFER?

PPO providers offer quality health care at a reduced cost. You are services by excellent community-based physicians and highly respected hospitals.

Your benefit plan has been enhanced to allow you to pay less out-of-pocket if you use PPO providers. Therefore, you save while receiving quality health care through PPO providers.

You will fill out no forms (except for required signatures) with the PPO. The physician's office or hospital handles all paperwork for you.

You have the CHOICE of using either a PPO provider or a non-PPO provider every time you seek medical services.

WHAT TYPES OF CARE ARE COVERED?

Your group benefit program describes the features and coverage levels available to you when you use PPO providers. THE PPO DOES NOT DETERMINE WHICH SERVICES ARE OR ARE NOT COVERED UNDER YOUR PLAN, BUT RATHER PROVIDES A MORE COST EFFECTIVE OPTION FOR RECEIVING THE BENEFITS WITHIN YOUR PLAN.

HOW DO I FIND A PPO PHYSICIAN?

You will receive a preferred provider directory: a complete list of physicians, their specialties, office locations and telephone numbers. Physicians are located throughout the area. As the network of health care providers expands, you will be issued additions and updated directories or directed to an alternative source, such as a toll-free telephone number to obtain updated information.

DO I HAVE TO USE ONLY PPO PROVIDERS?

No. By using PPO providers, you receive excellent care while paying less for it. However, since you are still covered under your traditional health plan, you can use a non-PPO provider at any time.

HOW DO I IDENTIFY MYSELF AS A PPO PATIENT?

You will receive an identification card. When you visit a PPO provider present your card, pay your applicable service fee and they will take care of the rest.

HOW ARE CLAIMS HANDLED?

When you present your ID card at the time of service, all paperwork will be handled for you. You will initially be asked to sign an assignment of benefits form to permit the provider to handle this process efficiently.