JEFFERSON COUNTY GOVERNMENT

EMPLOYEE HEALTH PLAN

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SCHEDULE OF MEDICAL BENEFITS

BENEFITS	PPO	NON-PPO
RETAIL PRESCRIPTION DRUG BENEFIT (through CVS Caremark)	Plan pays 75% of the drug cost (no deductible) with $10 min per fill, to Plan Year max out-of-pocket of $4,000/person and $8,000/family for retail and mail order drugs combined. **If Brand is purchased and Generic is available, Covered Person pays 25% plus the difference in cost between Generic and Brand**	
MAIL ORDER DRUG BENEFIT (through CVS Caremark Mail Service Pharmacy)	Plan pays 80% of the drug cost (no deductible) with $5 minimum and $25 maximum per fill, to Plan Year max out-of-pocket of $4,100/person and $8,200/family for retail and mail order drugs combined. **If Brand is purchased and Generic is available, Covered Person pays 20% plus the difference in cost between Generic and Brand**	
PLAN YEAR DEDUCTIBLE (no cross application between PPO and non-PPO deductibles) Per Person Per Family	 $1,000 $2,000	 $2,000 $4,000
BENEFIT PERCENTAGE PAYABLE	80%	50%
COINSURANCE/ CO-PAY MAXIMUM OUT-OF-POCKET PER PLAN YEAR (excluding prescription drug coinsurance and deductible)**. No cross application between PPO and non-PPO Coinsurance Max Out-of-Pocket amounts)** Per Person Per Family	 $3,000 $6,000	 $6,000 $12,000
AMBULANCE	80% after deductible	
SECOND SURGICAL OPINION BENEFIT	100%; deductible waived	
INPATIENT HOSPITAL **Co-Payment per Confinement**	80% after deductible None	50% after deductible $200
EMERGENCY ROOM for Emergency Care **Co-Payment per Visit (waived if admitted)**	80% after deductible $300	
PHYSICIAN OFFICE VISIT **Primary Care Physician (PCP)Co-Payment per Visit** **Specialist Physician Co-Payment per Visit**	100%, deductible waived $20 Copay/Visit $40 Copay/Visit	50% after deductible
TELEDOC VISIT	$10 Copay/Visit	
SPEECH THERAPY (limited to max of 20 visits per plan year)	80% after deductible	50% after deductible
OUTPATIENT PHYSICAL THERAPY (maximum of 20 visits/Plan Year)	80% after deductible	50% after deductible
OUTPATIENT MENTAL/NERVOUS/SUBSTANCE ABUSE **Co-Payment per visit**	100%, deductible waived $20	50% after deductible None
VOLUNTARY STERILIZATION (100%, deductible waived for females)	80% after deductible	Not Covered
HOME HEALTH CARE	80% after deductible to max of 100 visits/plan year	Not Covered
TEMPOROMANDIBULAR JOINT DYSFUNCTION	80% after deductible	Not Covered
SKILLED NURSING FACILITY – max 100 days/plan yr **Co-Payment per admission**	80% after deductible $100	50% after deductible $200
HOSPICE	80% after deductible	Not Covered
CHIROPRACTIC SERVICES (max 20 visits/plan yr) **Co-Payment per visit**	80% after deductible $40	50% after deductible None
PREVENTIVE CARE (as required under the ACA)	100%, deductible waived	Not Covered
SURGERY	80% after deductible	50% after deductible
DIAGNOSTIC X-RAY AND LAB	80% after deductible	50% after deductible
RADIOTHERAPY AND CHEMOTHERAPY	80% after deductible	50% after deductible
INHALATION THERAPY	80% after deductible	50% after deductible
DURABLE MEDICAL EQUIPMENT	80% after deductible	50% after deductible

PRE-ADMISSION NOTIFICATION IS REQUIRED FOR ALL NON-EMERGENCY HOSPITAL ADMISSIONS. POST-ADMISSION NOTIFICATION IS REQUIRED FOR ALL EMERGENCY HOSPITAL ADMISSIONS. IF NOT RECEIVED, A PENALTY OF $200 WILL BE APPLIED TO THE HOSPITAL CONFINEMENT.

SCHEDULE OF DENTAL BENEFITS

PLAN YEAR DEDUCTIBLE	
TYPE I SERVICES	NONE
TYPE II, III AND ORTHODONTIC SERVICES*	$50 PER PERSON $100 PER FAMILY
BENEFIT PERCENTAGES	
TYPE I SERVICES	100% OF REASONABLE CHARGE
TYPE II SERVICES	80% OF REASONABLE CHARGE
TYPE III SERVICES	80% OF REASONABLE CHARGE
ORTHODONTIC SERVICES*	60% OF REASONABLE CHARGE
MAXIMUM BENEFIT PAYABLE PER PLAN YEAR	
TYPE I, II & III SERVICES COMBINED	$1,500 PER PERSON
MAXIMUM LIFETIME BENEFIT	
ORTHODONTIC SERVICES*	$1,000 PER PERSON

* Orthodontic Services are only provided to Eligible Dependent children to age 18.

SCHEDULE OF VISION BENEFITS

VISION EXAMINATION	$50
LENSES (Per Pair) and Frames	
SINGLE VISION	$300
BIFOCALS	$300
TRIFOCALS	$300
CONTACT LENSES (Per Pair)*	
NECESSARY	$300
COSMETIC	$100

(Contact lenses can be allowed in lieu of lenses and frames)

* Note: the amount for a single lens is 50% of the amounts shown for a pair of lenses.

PRE-ADMISSION/POST-ADMISSION NOTIFICATION PROGRAM

The ID card will reflect the information for the Pre-Admission/Post-Admission Notification Program.
This Program does not apply to Covered Persons for whom Medicare pays its benefits as primary carrier. If this Program is not followed by the Covered Person, a penalty of $200 will be applied to the Hospital confinement. No penalty will be applied for any Hospital stay in connection with childbirth for the mother or newborn child, provided such stay is less than forty-eight (48) hours following a normal vaginal delivery or less than ninety-six (96) hours following a cesarean section. The penalty will apply for the failure to call for any Hospital stay in connection with childbirth for the mother or newborn child if such stay is forty-eight (48) hours or more following a normal vaginal delivery or ninety-six (96) hours or more following a cesarean section. Instructions for using this program are as follows:
Non-Emergency Hospital Admission. Calls for non-emergency hospital admissions should be made as soon as it is known that the Covered Person needs to be admitted.
Emergency Hospital Admission. If the Covered Person is admitted to the Hospital on an Emergency basis, the call must be made by the next business day following the date of admission.
Observation. If the Covered Person is in observation status for a period of twenty-four (24) hours or more, it will be treated as an admission for purposes of this provision.
A Partial Confinement will also be subject to the terms of this Program. The Pre-Admission/Post-Admission Notification Program does not guarantee benefits. All benefits are subject to the terms of this Plan. The Pre-Admission/Post-Admission Notification Program applies to each Hospital admission, and if a patient is transferred from one Hospital to another Hospital, the same procedures will need to be followed for each Hospital confinement. If the patient is unconscious or unable to follow the requirements of this Program due to Illness or Injury rendering the patient physically or mentally incapable, the penalty will be waived until the patient is able to follow the terms of the Program.

CASE MANAGEMENT

Case management coordinates care between the Covered Person and Physicians, facilities, and other providers. Case management will be instituted by the Plan when the Plan determines that it would be appropriate (based on diagnosis, procedures, and/or ongoing treatment). If case management is implemented, each Covered Person is required to participate in it and to fully cooperate with the case manager. When case management is instituted, the case manager will obtain information from the Physician(s), discharge planner(s), social worker(s), and/or other providers of health care services and supplies. The case manager will attempt to identify options that will preserve the Covered Person's benefits. Case management options will be communicated to the Covered Person, Eligible Employee, family member(s), and/or Physician(s). The Covered Person, the Covered Person's legal guardian, if any, or the Eligible Employee always has the option to pursue the treatment program of choice; however, the case manager will identify which treatment programs will be covered under the Plan.

PREFERRED PROVIDER PLAN

For purposes of this Plan, the term "PPO Provider" means a Physician, Hospital or other provider that has an agreement with the PPO to provide supplies or services at negotiated rates. The Plan will allow the amount that is negotiated between the PPO and its PPO Providers. If there is a per diem rate that is negotiated between the PPO and a PPO Provider, the per diem amount will be allowed as the eligible expense. The PPO information will be reflected on the ID cards. The payment rates vary between PPO Providers and non-PPO Providers, as described on the Schedule of Medical Benefits. Since PPO Providers have agreed to negotiated rates, Covered Persons will not be billed for amounts over the Reasonable and Customary Charge if they use PPO Providers**. In the event that a Covered Person requires Emergency Care, the PPO level of benefits will apply to such charges, even if rendered by non-PPO Providers**. If a Covered Person uses a Physician who is a PPO Provider and a Hospital that is a PPO Provider for a given procedure, any assistant surgeon, anesthesiologist, radiologist, and pathologist charges in connection with that procedure will be payable at the PPO level of benefits, even if rendered by non-PPO Providers. Charges for prescription drugs that are covered under the medical plan (and not the Prescription Drug or Mail Order Drug Benefit) will be payable as if these charges had been rendered by a PPO Provider. If a Covered Person is traveling or living outside of the PPO area and incurs medical expenses, such expenses will be payable at the PPO level of benefits. If a Covered Person is confined in a Hospital that is a PPO Provider and is seen by a Non-PPO Physician for an in-hospital visit, while confined, the visit(s) will be payable at the PPO level of benefits.

RETAIL PRESCRIPTION DRUG BENEFIT

The Retail Prescription Drug Benefit covers Medically Necessary drugs which may be lawfully dispensed only upon the written prescription of a Physician. This benefit will cover up to the greater of a 34-day supply or quantity of 100. This benefit also covers Retin-A for Covered Persons through the age of 24 years, oral contraceptives, Seasonale, insulin needles and syringes, and injectable insulin.
Each Covered Person will receive a CVS Caremark identification card. When a Covered Person presents the card to a member pharmacy, he need only pay the pharmacist his share of the coinsurance as shown in the Schedule of Medical Benefits for any prescription, filled or refilled. This drug coinsurance will not apply to the deductible or Coinsurance Maximum Out-of-Pocket amount.
The following items are covered at 100%, not subject to any coinsurance:

1. Smoking cessation products, to a limit of 168 day supply in one year of treatment with Generic Nicotine replacement products (Nicotine patch, gum and lozenges) and a limit of 168 day supply in one year of treatment with Generic Zyban or Chantix. This includes prescription and over-the-counter drugs, but there must be a Physician’s prescription and covered drugs must be on the CVS Caremark defined drug list.
2. Folic acid products for females under age 56, to a maximum of 100 units per fill, for Generic Drugs only that are on the CVS Caremark defined drug list.
3. FDA approved contraceptives.

4. Certain immunizations.

If a Physician prescribes a Brand Drug, and a Generic Drug is available, and the Covered Person chooses the Brand drug, then the Covered Person must pay his share of the coinsurance for the Brand Drug plus the difference in cost between the Brand Drug and the Generic Drug. If a Physician prescribes a Brand Drug, and a Generic Drug is not available, then the Covered Person will only need to pay his share of the coinsurance for the Brand Drug.

The Employer may choose to administer the prescription drug program on a reimbursement basis, without the use of CVS Caremark. If this is the case, the employee will submit drug expenses on a medical claim form and be reimbursed by the Plan for eligible prescription drug expenses at the rate shown in the Schedule of Medical Benefits.

This benefit includes a Step Therapy program, which is administered by the Plan's pharmacy benefit manager. Under the Step Therapy program, certain classes of drugs require utilization of generic or preferred brand drugs, before a non-preferred brand is covered. A list of Step Therapy drugs may be obtained from the Plan's pharmacy benefit manager.

The following charges are excluded under this benefit: anabolic steroids; contraceptives other than oral contraceptives or Seasonale; anorectics (any drug used for the purpose of weight loss); anti-wrinkle agents (e.g. Renova), regardless of intended use; growth hormones; hair removal products; immunization agents; blood or blood plasma; infertility drugs; minoxidil (e.g. Rogaine) for the treatment of alopecia; pigmenting/depigmenting agents; Retin-A for Covered Persons age 25 and older; smoking deterrent or cessation aids; therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use (other than as specified herein);vitamins (including prescription vitamins); charges for the administration or injection of any drug; drugs labeled "Caution - limited by federal law to investigational use," or Experimental/Investigational drugs, even though a charge is made to the Covered Person; and medication which is to be taken by or administered to a Covered Person, in whole or in part, while he is a patient in a licensed Hospital, rest home, sanitarium, Convalescent Facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

MAIL ORDER DRUG BENEFIT

The Mail Order Drug Benefit will be administered by CVS Caremark Mail Service Pharmacy. This benefit covers a ninety- (90) day supply of many maintenance medications, based on the benefit payable that is specified in the Schedule of Medical Benefits. The drugs that are excluded in the Prescription Drug Benefit are also excluded in the Mail Order Drug Benefit. When a Covered Person purchases Mail Order Drugs, he need only pay his share of the coinsurance as shown in the Schedule of Medical Benefits for any prescription, filled or refilled. This drug coinsurance will not apply to the deductible or Coinsurance Maximum Out-of-Pocket amount.

MEDICAL EXPENSE BENEFITS

Coinsurance/Co-Pay Maximum Out-of-Pocket

The Coinsurance/Co-Pay Maximum Out-of-Pocket amount that is specified in the Schedule of Medical Benefits refers to the maximum amount any Covered Person or covered family will have to pay in any Plan Year in coinsurance (not including prescription drug coinsurance) and/or co-pays. Once this amount has been met, the remainder of benefits for that Plan Year will be payable at 100%. The Coinsurance/Co-Pay Maximum Out-of-Pocket amount does not include the deductible, penalties, or charges that are excluded or that exceed limits outlined in this Plan. PPO and non-PPO Coinsurance Maximum Out-of-Pocket amounts shall not be applied toward each other.

Deductible

The deductible is the amount of covered medical expenses which each Covered Person must pay before benefits are provided under these provisions. The deductible amount is specified in the Schedule of Medical Benefits. The deductible applies only once during any Plan Year, even though a person may have several different accidents or Illnesses. PPO and non-PPO deductibles amounts shall be applied toward each other.

Family Deductible

The deductible applies to each person separately, but if the members of a family have incurred deductible charges in excess of the family deductible amount specified in the Schedule of Medical Benefits, no further deductible will be required for any other member of the family for the balance of that Plan Year.

COVID-19 (CORONAVIRUS)

1. Deductibles, co-pays and cost sharing on covered participants for COVID-19 testing shall be waived.
2. Cost sharing shall be waived for office and other outpatient services; hospital observation service; emergency department services; nursing facility services; domiciliary, rest home or custodial care services; home services; or online digita evaluation and management services.

This will terminate when an applicable Federal or State authority lifts the State of Emergency related to Coronavirus (COVID-19), and/or as determined by the Plan Administrator.

Eligible Expenses

The following services and supplies are covered expenses under this Plan:

1. Hospital charges (at the Semi-Private Room Rate) for room and board and miscellaneous expenses. This Semi-Private Room Rate limit does not apply to charges for intensive care and coronary care units. In addition, charges that are in excess of the Semi-Private Room Rate will be covered in full if the Physician certifies that the patient should be in isolation. Two (2) days of Partial Confinement in a Hospital will be considered as one (1) day of confinement. Emergency room benefits for Emergency Care are as described in the Schedule of Medical Benefits. If care is received in a room that does not meet the definition of

Emergency Care, benefits will be payable at the regular percentage rates based on if a PPO or non-PPO provider is used. In addition, a penalty of 50% of the charge will be applied to the emergency room bill. This penalty will not apply toward the deductible or Coinsurance Maximum Out-of-Pocket.

2. Physicians' charges for treatment of an Illness or Injury (including charges for an elective sterilization rendered by a PPO provider for an Eligible Employee or Eligible Employee's spouse only [this includes the Essure procedure]). For surgery claims, the allowable amount for an assistant surgeon will be 20% of the allowance for the primary surgeon, and Medicare RBRVS will be used to determine allowable amounts for (1) multiple surgeries performed on the same day or at the same session; (2) bilateral surgeries; (3) co-surgery and team surgery; and (4) services rendered by a Physician's Assistant. Physician office visits are payable as specified in the Schedule of Medical Benefits. Office visits are visits to a Physician where an evaluation or treatment is rendered. The Physician Office Visit benefit will include charges for both an office visit and diagnostic testing relating to hearing testing, provided such services are rendered by a PPO provider (such services are payable at 100% subject to the per visit co-payment outlined in the Schedule of Medical Benefits). Physician charges for a second surgical opinion are payable as specified in the Schedule of Medical Benefits. For this benefit to be payable, the Physician who is being consulted shall be a board certified surgeon in the appropriate specialty, shall not be affiliated in any way with the Physician who will be performing the actual surgery, and shall not assist with the surgery.
3. Charges for diagnostic x-ray and laboratory examinations.
4. Charges for chemotherapy and x-ray, radium and radioactive isotope therapy.
5. Charges for medical appliances, crutches, dressings, and other equipment.
6. Charges for anesthesia and the administration thereof.
7. Charges for blood and blood plasma, to the extent it is not donated or otherwise replaced.
8. Charges for the rental of Durable Medical Equipment under a lease acceptable to the Plan. The Plan may, in its discretion, authorize purchase of such equipment.
9. Charges for physical therapy prescribed by the attending Physician as to type and duration when performed by a licensed physical therapist.
10. Charges for occupational therapy prescribed by the attending Physician as to type and duration when performed by a licensed occupational therapist (however, charges incurred for supplies used in connection with occupational therapy are not covered).
11. Charges for orthopedic braces (except corrective shoes) and prosthetic appliances (including replacements required as a result of the Covered Person's natural growth and development).
12. Charges for professional ambulance service when used in emergency situations to transport a Covered Person from the place of accidental Injury or acute medical episode to the nearest Hospital where required treatment is given. Ambulance charges incurred to transport a Covered Person from one Hospital to another Hospital will be covered only if the first Hospital is not equipped to treat the Covered Person's medical condition. Ambulance charges will only be covered if the attending Physician certifies that such transportation is Medically Necessary. No other charges for transportation or travel will be covered.
13. Charges for a Physician's or speech therapist's fees for restoratory or rehabilitory speech therapy for speech loss or impairment due to an Illness or Injury, other than a functional nervous disorder, or due to surgery performed on account of an Illness or Injury. If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.
14. Charges for maternity. Covered charges include obstetrical services, prenatal and postnatal care. Any services provided by a Nurse-Midwife acting within the scope of a license which allows for providing such services will be payable on the same basis as services provided by a Physician. Charges incurred in a Freestanding Birthing Facility will be payable as if they had been incurred in a Hospital. If an Employee has dependent coverage, the Plan covers Hospital and Physician charges for Medically Necessary and/or routine care for the newborn well baby while the baby is in the Hospital. The Plan also covers charges for the baby's circumcision.
15. Charges for care rendered by a Hospice. Such care is only covered if rendered by a PPO provider. Covered charges include room and board charged by the Hospice; miscellaneous services and supplies; part-time nursing care by or under the supervision of a registered graduate nurse; home health care services; and counseling services by a licensed social worker or a licensed pastoral counselor for the patient and the patient's Close Relatives. Such care is only covered if a Physician has certified that the patient is terminally ill and the patient's life expectancy is six (6) months or less.
16. Charges for care in a Skilled Nursing Facility if a Physician determines that the Covered Person requires skilled nursing care. This benefit is limited to the maximum number of days per Plan Year that is specified in the Schedule of Medical Benefits. Admission to the Skilled Nursing Facility must be within seven (7) days of an acute care Hospital confinement of not less than three (3) days, and the admission to the Skilled Nursing Facility must be for the same or related condition as the Hospital confinement.
17. Charges for home care visits rendered through a Home Health Care Agency, provided the Physician certifies the medical necessity of home health care. This benefit is only provided to PPO Providers, and it is limited to the maximum number of days per Plan Year that is specified in the Schedule of Medical Benefits. The allowed home care services are the usual and customary services of the Home Health Care Agency which are not specifically excluded hereunder and services provided on an Outpatient basis in a Hospital when such services cannot readily be made available at the Covered Person's place of residence. For the purposes of determining the visits limitation, a visit is a personal contact in the Covered Person's home made for the purpose of providing a covered service by a health worker on the staff of a home care agency or by others under contract or arrangements made with such agency. However, if a service lasts more than four (4) consecutive hours, each four (4) hour segment or part of a segment will be counted as one (1) visit. The following services and supplies are covered: part-time or intermittent nursing care and initial evaluation; physical, occupational and speech therapy; medical social services; part-time or intermittent services of home health aides; dietary guidance; medical services and supplies necessary for the treatment of a condition for which the home health care service is required; the use of medical appliances; and services provided on an ambulatory care basis when such services cannot readily be made available in the Covered Person's home. Notwithstanding anything to the contrary herein set forth, home care services do not include: meals; professional medical services billed for by a Physician; Custodial Care; services of housekeepers; prescription and non-prescription drugs and biologicals; and services of a Close Relative or members of the Covered Person's household.

18. Charges for services and supplies furnished in connection with covered transplant procedures, subject to the following conditions:
    a. If the recipient is covered under this Plan, eligible medical expenses incurred by the recipient will be considered for benefits. Expenses incurred by the donor, who is not ordinarily covered under this Plan according to participant eligibility requirements, will be considered eligible expenses to the extent that such expenses are not payable by the donor's plan. The donor's charges will be payable as if they had been incurred by the recipient.
    b. If both the donor and the recipient are covered under this Plan, eligible medical expenses incurred by each person will be considered as the recipient's charge.
    c. the reasonable and customary cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, will be considered a covered expense.
19. Charges for the following when a Covered Person is receiving benefits in connection with a mastectomy and elects breast reconstruction in connection with such mastectomy:
    a. reconstruction of the breast on which the mastectomy has been performed;
    b. surgery and reconstruction of the other breast to produce a symmetrical appearance;
    c. treatment of physical complications of all stages of mastectomy, including lymphedemas; and
    d. prostheses.

    in a manner determined in consultation with the attending Physician and such Covered Person.
20. Charges for peritoneal dialysis, renal dialysis or other dialysis procedures performed at the Covered Person's home or on an Inpatient or Outpatient basis in a Hospital or Freestanding Dialysis Facility. Dialysis performed to treat drug addiction will be subject to the limits (if any) outlined in the Plan for such drug addiction treatment.
21. Charges for Preventive Care services which are included in the Affordable Care Act. A description of covered services can be found on healthcare.gov under the prevention category
22. Charges for treatment of jaw joint problems, including temporomandibular joint dysfunction (TMJ) syndrome and conditions of structures linking the jaw bone and skull and the complex of muscles, nerves, and other tissues related to that joint. Covered services include, but are not limited to: orthopedic (not orthodontic) appliances and physical therapy. Such care is only covered if rendered by a PPO provider.
23. Charges for oxygen and the administration thereof.
24. Charges for the services of a registered professional nurse (R.N.) and for the services of a licensed practical nurse (L.P.N.) other than a nurse who ordinarily resides in the Covered Person's home, or is a Close Relative.
25. Charges by a licensed pharmacist or Physician for such drugs and medicines which can be purchased only upon a Physician's prescription (other than those drugs that are excluded herein and other than those drugs that are covered under the Prescription Drug Benefit or the Mail Order Drug Benefit). The drugs covered under the medical plan will be payable at the PPO level of benefits.
26. Charges for care rendered in an Alcoholism Treatment Facility (payable as if such charges were incurred in a Hospital).
27. Charges for care rendered in an Ambulatory Surgical Center.
28. Charges for care rendered in an Urgent Care Facility.
29. Charges for a Hospital Outpatient department cardiac rehabilitation program. This benefit will only be payable if all of the following conditions have been met:
    a. the person has had myocardial infarction, coronary bypass surgery, stable angina pectoris, angioplasty, or a heart transplant;
    b. the person starts his cardiac rehabilitation program within twelve (12) months after discharge from the Hospital; and
    c. the cardiac rehabilitation program is rendered in the Hospital's Outpatient department or in a Medicare-approved facility for cardiac rehabilitation.
30. Charges for inhalation therapy.
31. Charges for hearing aids supplied by PPO providers only, including replacements but not including repairs and replacement batteries.
32. Charges for Enteral Formulae, which is a liquid source of nutrition administered under the direction of a Physician, which may contain some or all the nutrients necessary to meet minimum daily nutritional requirements, and is administered into the gastrointestinal tract through a tube. Coverage is provided for Enteral Formulae when administered on an Outpatient basis, primarily for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary metabolic disorders. Coverage is also provided for Enteral Formulae when administered on an Outpatient basis, when Medically Necessary for a medical condition, when considered to be the sole source of nutrition and when provided through a feeding tube and utilized instead of regular shelf food or infant formulas. Once it is determined that a Covered Person meets these criteria, coverage will continue as long as the Formulae represents at least 50% of the daily caloric requirement. The following are excluded under this benefit: blenderized food, baby food, or regular shelf food when used with an enteral system; milk or soy based infant formulae with intact proteins; any formulae, when used for convenience; nutritional supplements or any other substance utilizaed for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance; the following formulae when provided orally: semi-synthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; and normal food products used in the dietary management of rare hereditary genetic metabolic disorders.
33. Charges for one wig coincident with or following chemotherapy, to a maximum benefit of $200 per lifetime.
34. Charges for mental health and substance abuse, in compliance with Ohio and federal mental health parity laws.
35. Charges for Routine Patient Costs for Qualified Individuals to participate in an Approved Clinical Trial. For purposes of this coverage, the following definitions apply:
    a. Routine Patient Costs include items and services typically provided under the Plan for a participant not enrolled in a clinical trial. However, such items and services do not include (1) the investigational item, device or service itself; (2) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (3) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

b. Qualified Individual is a Covered Person who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other Life-Threatening Condition and either (1) the referring health care professional is a participating provider and has concluded that the Covered Person's participation in the clinical trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.
c. Approved Clinical Trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other Life-Threatening Condition and is federally funded through a variety of entities or departments of the federal government; is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration; or is exempt from investigational new drug application requirements.
d. Life-Threatening Condition is a disease or condition likely to result in death unless the disease or condition is interrupted.

MAXIMUM BENEFIT

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

MEDICAL PLAN LIMITATIONS AND EXCLUSIONS

The following charges are limited or excluded under the Plan:

1. Charges for the reversal of an elective sterilization or charges that result from complications from that procedure.
2. Charges for services or supplies that cannot be reasonably expected to contribute to the improvement of the patient's condition, Illness or Injury.
3. Charges incurred in connection with eye refractions, the purchase or fitting of eyeglasses, contact lenses, or such similar aid devices. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery..
4. Charges for dental care (unless such treatment is rendered as a result of and within one year following an accidental Injury sustained while covered under the Employer's Plan, or unless such treatment is for the excision of bony impacted, unerupted teeth, or for the excision of a tumor or cysts, or the incision and drainage of an abscess or cyst). In addition, if it is Medically Necessary that a Covered Person be treated at a Hospital for a dental condition, the Hospital charges will be a covered expense.
5. Charges for Custodial Care.
6. Charges for Hospital room and board and general nursing care when the Covered Person is admitted primarily for diagnostic study or medical observation and the necessary care can properly be provided on an Outpatient basis.
7. Charges for personal services not required in the diagnosis or treatment of an Illness or Injury, including but not limited to TV, telephone, guest trays, guest beds, reading materials, and other guest-related requests.
8. Charges for Cosmetic Surgery unless required because of an accidental Injury which occurs while covered under the Employer's Plan; because of a congenital malformation of a dependent child; due to replacement of diseased tissue which has been surgically removed; or as specified herein.
9. Charges for treatment of bunions (except by capsular or bone surgery); toe nails (except surgery for ingrown nails); corns; calluses; fallen arches; flat feet; weak feet; chronic foot strain; symptomatic complaints of the feet; purchase of orthopedic shoes; or orthotics that are prescribed to treat a foot condition that is not covered. However, this exclusion will not apply to treatment of skin of the feet or toenails if the patient is diabetic.
10. Charges for services which are not Medically Necessary (except as specified herein) or which have not been recommended by a Physician
11. Charges which are in excess of the Reasonable and Customary Charge.
12. Charges for Preventive/Maintenance Care, routine physical examinations, and immunizations (except as specified herein).
13. Charges for vitamins, minerals or dietary supplements.
14. Charges for sex transformation and hormones related to such treatment and charges for related psychiatric care.
15. Charges for recreational or educational therapy, including biofeedback training.
16. Charges for marital counseling.
17. Charges for hair replacement, transplants or stimulants.
18. Charges incurred in connection with any treatment, therapy, teaching technique or program for remedial education or habilitative or rehabilitative training which is principally intended to overcome, ameliorate or compensate for any learning impairment whatsoever, regardless of whether such impairment is diagnosed as functional or organic.
19. Charges for enrollment in a health, athletic, or similar club; for a non-smoking or similar program; or for any treatment of obesity including diet control or diet supplements, except for surgical treatment of morbid obesity which is determined to be in excess of 70% of standard weight tables (such treatment is only covered if the morbid obesity is determined as secondary diagnosis to an otherwise life-threatening condition).
20. Charges for any surgical procedure for the correction of a visual refractive problem.
21. Charges for vision therapy and any related diagnostic testing.
22. Charges for services rendered by a Physician, nurse or licensed therapist if such Physician, nurse, or licensed therapist is a Close Relative of the Covered Person, or resides in the same household as the Covered Person.
23. Charges for artificial methods of conception (including but not limited to in-vitro or in-vivo fertilization, artificial insemination, surrogate parenting procedures, embryonic transplant, GIFT or ZIFT) and related tests; or fertility drugs.
24. Charges for any service which is due or related to complications arising from treatment of services otherwise excluded.
25. Charges which were incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.
26. Charges for enteral/supplemental feedings purchased as over-the-counter supplements.
27. Charges for hypnosis, acupuncture, or other alternative medical treatments.
28. Charges for follow-up care in an emergency room.
29. Charges for counseling for borderline intellectual functioning or developmental disorders.
30. Charges incurred in connection with travel expenses of a Covered Person (other than as specified herein) or a provider.
31. Charges for an elective abortion. Charges for an elective abortion will be a covered expense where the life of the mother would be endangered if the fetus were carried to term. If medical complications have arisen from an abortion, charges for treatment of those complications will also be covered expenses.
32. Charges for care or treatment of an Injury or Illness arising out of the course of any employment or occupation for wages or profit, or for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease law, whether or not any coverage for such benefits is actually in force.
33. Charges for care in any Hospital owned or operated by any federal government, with the exception of charges for care in a V.A. Hospital for veterans who have non-service-connected disabilities or for Inpatient care in a military Hospital for military retirees, dependents of retirees and dependents of active military personnel.
34. Charges resulting from any intentionally self-inflicted Injury or Illness, unless due to domestic violence or a medical condition; and charges for Illness or Injury caused by or contributed to by engaging in an illegal occupation or by committing or attempting to commit a felony or assault.

35. Charges for any services received as a result of Injury or Illness due to an act of war which has occurred after the effective date of the Covered Person's coverage, or caused during service in the armed forces of any country, or due to participation in a riot.
36. Charges incurred which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.
37. Charges for appointments not kept, or for the completion of claim forms.
38. Charges for Experimental or Investigational procedures.
39. Charges for room and board incurred in connection with a Hospital admittance on Friday, Saturday, or holiday unless significant medical treatment is given on those days; significant medical treatment includes any treatment not normally connected with room, board or general nursing services.
40. Charges for purchase or rental of supplies of common use such as exercise cycles, air purifiers, air conditioners, water purifiers, hypoallergenic pillows or mattresses or waterbeds.
41. Charges for purchase or rental of escalators, elevators, saunas, steambaths, swimming pools, or blood pressure kits.
42. Charges for materials used in occupational therapy.
43. Charges for services which are not performed according to accepted standards of medical practice for the condition being treated.
44. Charges for procedures, services, supplies and prescription drugs related to sexual dysfunction, including but not limited to penile implants.

DENTAL BENEFITS

Amount Payable
Benefits are payable for each type of service after the deductible (if any) for that type of service has been satisfied. Benefits are payable at the percentage rate applicable to the type of service. Both the deductible and percentage rates applicable for each type of service are specified in the Schedule of Dental Benefits.

Deductible
The deductible is the amount of covered dental expenses which must first be paid by the Covered Person before benefits for Type II, Type III and Orthodontic Services are payable. The deductible applies only once each Plan Year.

Family Deductible
If, in any Plan Year, the members of a family incur charges toward their deductible equal to the family deductible amount specified in the Schedule of Dental Benefits, no further deductible is required in connection with any other family member for the balance of that Plan Year.

Three Month Carryover Deductible
Any dental expenses incurred during the last three (3) months of a Plan Year which apply toward the deductible for that year will also be applied toward the deductible for the next Plan Year.

Maximum Benefit
The maximum benefit payable for each person in any Plan Year for Type I, II and III Services combined is specified in the Schedule of Dental Benefits. The maximum lifetime benefit payable for each person for Orthodontic Services is specified in the Schedule of Dental Benefits.

Pre-Determination of Benefits
If the charges for a proposed course of treatment are expected to exceed $200, each Covered Person can take advantage of a Pre-Determination of Benefits provision. Under this provision, the Covered Person files with Self-Funded Plans, Inc. a Dentist's diagnosis, proposed course of treatment, and expected charges. The Dentist may complete this information on a dental claim form. When a Pre-Determination of Benefits has been made, Self-Funded Plan, Inc. will inform the Covered Person, in advance of treatment, as to the estimated amount of any benefits payable under this Plan with respect to the proposed course of treatment.

Benefits for Temporary Work
Benefits for temporary dental service will be considered a part of the final dental service. Benefits paid for temporary service will be deducted from the benefits otherwise payable for the final service.

Alternate Treatment
If alternate services or supplies may be employed to treat a dental condition, Covered Dental Expenses will be limited to the Reasonable and Customary charge for those services or supplies which are customarily employed nationwide in the treatment of the Illness or Injury and are recognized by the profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account the current total oral condition of the covered family member.

Covered Dental Expenses
Covered Dental Expenses are the Reasonable and Customary Charges of a Dentist which the Employee is required to pay for services and supplies listed below which are received by a covered family member in connection with a course of treatment; but only to the extent that the Plan determines that the services rendered and supplies furnished and the course of treatment are appropriate and meet professionally recognized national standards of quality; and are necessary for the treatment of a non-occupational Illness or a non-occupational Injury and are customarily employed nationwide for the treatment of the dental condition; taking into account the current total oral condition of the covered family member. The following is a complete list of those dental services which will be considered as Covered Dental Expenses; however, expenses that are incurred for the performance of any dental service not listed below will be considered a Covered Dental Expense only if the Plan Administrator agrees in writing to accept such expenses as Covered Dental

Expenses. If the Plan Administrator so agrees, the benefits that are payable will be consistent with a payment for such similar Covered Dental Expenses that would provide the least costly professionally adequate treatment.

Type I Services
1. Routine oral exams, but not more than two (2) examinations in any Plan Year.
2. Prophylaxis, but not more than two (2) prophylaxis treatments in any Plan Year.
3. X-rays. Supplementary bitewing x-rays are covered twice per Plan Year. Full-mouth ex-rays are covered once in any period of 36 consecutive months.
4. Topical application of sodium or stannous fluoride, but only if the covered family member has not yet attained the age of fifteen (15) years. Such charges will be covered up to twice in a Plan Year.
5. Emergency pain treatments.
6. Space maintainers for Covered Persons under age nineteen. All adjustments within six (6) consecutive months of installation are covered.
7. Tests and laboratory examinations including bacteriologic cultures, pulp vitality tests and diagnostic casts (study models).

Type II Services
1. Oral surgery (excluding any charges which are covered under the medical benefits plan).
2. Extractions.
3. Alveoplasty (surgical preparation of ridge for dentures) and tooth replantation.
4. Fillings (amalgam, acrylic, composite, synthetic porcelain and silicate).
5. General anesthetics administered in connection with oral surgery, only if Medically Necessary.
6. Endodontic treatment, including root canal therapy.
7. Injections of antibiotic drugs and application of desensitizing medication by the attending Dentist.
8. Repair or recementing of crowns, inlays, onlays, bridgework or dentures, or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, not to exceed one relining or rebasing in any period of 36 consecutive months.
9. Gingivectomy and osseous surgery and treatment of periodontal and other diseases of the gums and tissues of the mouth.

Type III Services
1. Inlays, onlays, gold fillings or crowns, but only when the tooth cannot be restored to proper function with an amalgam, silicate, acrylic, synthetic porcelain or composite filling.
2. Initial installation of removal partial, fixed partial or complete dentures (including adjustments for the six [6] month period following installation).
3. Initial installation of fixed bridgework (including inlays and crowns to form abutments).
4. Replacement of existing dentures or bridgework, but only when:
    a. the existing denture/bridge cannot be repaired and made serviceable;
    b. the existing denture/bridge, if installed while covered under the Employer's Plan, is at least five (5) years old; or
    c. the existing denture is an immediate temporary denture which must be replaced by a permanent denture within one (1) year.

Orthodontic Services
The term Orthodontic Procedure means the use of active appliances to move teeth, to correct faulty position of teeth (malposition), to correct abnormal bite (malocclusion), or to control harmful habits. Orthodontic Services are only provided for Eligible Dependent children to age 18. Related oral examinations, surgery and extractions are included.

An Orthodontic Treatment Plan means a Dentist's report, on a form approved by the Plan, that states the class of malocclusion or malposition; recommends and describes needed treatment by orthodontic procedures; estimates the duration of the treatment; estimates the total charge for the treatment; and includes cephalometric x-rays, study models and any other supporting evidence that the Plan may reasonably require.

A charge is an Eligible Charge if all these conditions are met:
1. It is made for a service or supply furnished in connection with an orthodontic procedure and before the end of the estimated duration shown in the orthodontic treatment plan.
2. The orthodontic procedure is needed to correct one of these conditions:
    a. vertical or horizontal overlap of upper teeth over lower teeth (overbite or overjet) of a least four millimeters; or
    b. faulty alignment (either frontwards or backwards) of the upper and lower arches with each other by at least the width of one tooth section (one cusp); or
    c. cross-bite; or
    d. control harmful habits.

Orthodontic benefits will be paid in equal installments. The Covered Person must be covered on the first day of each installment period in order to receive payment for that period. The first installment period will start on the date an active appliance is installed. The initial down payment will be payable at 20% of the total charge, payable at the coinsurance percentage. If orthodontic treatment is stopped for any reason before it is complete, the benefit will only pay for services and supplies actually received.

When Expenses Are Deemed to be Incurred
Expenses are deemed to be incurred as of the date dental care is performed, except as provided below:
1. Expenses for restorations shall be deemed incurred on the first date of preparation of the tooth or teeth involved, provided the person remains continuously covered during the course of treatment.

2. Expenses or charges for endodontic services shall be deemed incurred on the date the specific root canal procedure commenced, provided the person remains continuously covered during the course of treatment.
3. Expenses for fixed bridgework, crowns, inlays or restorations shall be deemed incurred on the first date of preparation of the tooth or teeth involved, provided the person remains continuously covered during the course of treatment.
4. Expenses for full or partial dentures shall be deemed incurred on the date the final impression is taken, provided the person remains continuously covered during the course of treatment.
5. Expenses for rebase of an existing partial or complete denture shall be deemed incurred on the first day of preparation of the rebase of such denture, provided the person remains continuously covered during the course of treatment.
6. Expenses or charges for orthodontia services shall be deemed incurred on the date the orthodontic procedure commenced, provided the person remains continuously covered during the course of treatment.

Dental Plan Limitations and Exclusions

Dental Expense Benefits do not cover expenses incurred for any of the following:

1. Charges for dental care which is provided solely for the purpose of improving appearance, when form and function of the teeth are satisfactory and no pathological condition exists, including charges for personalization or characterization of dentures.
2. Charges for treatment by other than a Dentist, except that cleaning or scaling of teeth and topical application of fluoride may be performed by a licensed Dental Hygienist, if such treatment is rendered under the supervision and direction of the Dentist.
3. Charges for dental care which does not meet the standards of dental practice accepted by the American Dental Association.
4. Charges for the replacement of a lost or stolen prosthetic device.
5. Charges for sealants, for oral hygiene instructions or dietary instruction, and for plaque control program.
6. Charges for appliances or restorations, other than full dentures, whose primary purpose is to increase vertical dimension or stabilize periodontally involved teeth, or to restore the occlusion (other than as specified herein).
7. Charges for services or supplies which are furnished prior to the effective date of coverage or after coverage has terminated. In the case of prosthetic devices and crowns, charges will not be covered if the impressions were taken before the date coverage commenced, even though the prosthetic device or crown is not installed until after the date coverage commenced.
8. Charges for replacement of a crown, bridge or denture within five years following the date of its original installation unless such replacement is made necessary by the placement of any original opposing full denture or the extraction of natural teeth; or the bridge or denture, while in the oral cavity, has been damaged beyond repair as a result of an injury received while the Covered Person is covered under the Employer's Plan.
9. Charges for adjustment or repair to a denture performed within six (6) months of the installation of the denture.
10. Charges for implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants.
11. Charges for periodontal splinting of teeth except for treatment of trauma.
12. Charges for facings on pontics or crowns posterior to the second bicuspid.
13. Charges for any spare, duplicate or replacement device other than as allowed herein.
14. Charges incurred for any treatment of temporomandibular joint (TMJ) disturbances.
15. Charges for care or treatment of an Injury or Illness arising out of the course of any employment or occupation for wages or profit, or for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease law, whether or not any coverage for such benefits is actually in force.
16. Charges for dental care which is furnished while a person is confined in a Hospital operated by the United States Government or any agency thereof (except in a foreign country), or dental care for which the person would not be required to pay if there were not benefits.
17. Charges for dental care resulting from any Injury sustained as a result of war, declared or undeclared.
18. Charges incurred which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.
19. Charges for appointments not kept, or for the completion of claim forms.
20. Charges which are in excess of the Reasonable and Customary Charge.
21. Charges, if any that are included as covered medical expenses.
22. Charges for dental care not included in the list of defined eligible expenses.
23. Charges made by a Dentist or Dental Hygienist who normally lives in the Covered Person's home, or is a Close Relative.

VISION EXPENSE BENEFITS

Vision Expense Benefits are payable based on the maximum benefits shown in the Schedule of Vision Benefits.

Time Period of Benefits

Vision examinations are covered once every twelve (12) months. Frames and lenses are limited to one complete set every twelve (12) month period. The time period will begin on the date on which the last payment of benefits for each item was made under this plan of benefits. Benefits for contact lenses will be in lieu of all other frames and lenses for the same benefit period.

Contact Lenses

Contact Lenses will be considered as necessary under the following circumstances:

1. If visual acuity is not correctable to 20/70 in the better eye, except by the use of contact lenses; or
2. If the patient is being treated for a condition, such as Keratoconus, or Anisometropia, and contact lenses are customarily used as part of the treatment; or
3. If required following cataract surgery.

Covered Vision Expenses
Vision exams include a complete analysis of the vision functions, including the prescription of lenses where indicated. Lenses include all lens material including tints, plastic multi-focal lenses and oversized lenses.

Vision Plan Limitations and Exclusions
There is no coverage for services and supplies for any of the following charges:
1. Charges for orthoptics, vision training, subnormal vision aids, aneseikonic lenses or plano lenses.
2. Charges for medical or surgical treatment of the eyes.
3. Charges for services and supplies not listed as a covered item.
4. Charges for sunglasses, frames for sunglasses, or safety lenses or goggles.
5. Charges for frames or lenses not needed to correct abnormal vision.
6. Charges for services or supplies which are furnished prior to the effective date of coverage or after coverage has terminated.
7. Charges for care or treatment of an Injury or Illness arising out of the course of any employment or occupation for wages or profit, or for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease law, whether or not any coverage for such benefits is actually in force.
8. Charges for services provided or paid for by any government or its agencies.
9. Charges for any services received as a result of Injury or Illness due to an act of war which has occurred after the effective date of the Covered Person's coverage, or caused during service in the armed forces of any country.
10. Charges incurred which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.
11. Charges for appointments not kept, or for the completion of claim forms.
12. Charges for lost or stolen lenses and frames.
13. Lenses and frames furnished under this Plan which are lost or broken will not be replaced, except at the normal intervals when services are otherwise available.
14. Charges for services rendered by a Close Relative.
15. Charges which are covered under the Medical Benefits plan.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

New Eligible Employees who are enrolled will be covered on the first day of the month coinciding with or next following the date they have satisfied the Waiting Period, (except that o Waiting Period will apply to elected officials or appointed Board of Election members; such persons will be effective on the first day of employment).

Eligible Employees who choose to join the HMO option will be covered for dental and vision benefits under this Plan.

Eligible Employees who are rehired within the six (6) month period following the date of termination of coverage will be covered on the date they return to work. If an Eligible Employee transfers from part-time to full-time status at any time during the month, his coverage shall begin on the first day of the month coinciding with or next following the date of the transfer, as long as the Waiting Period has been satisfied. Eligible Employees who return to work following a tour of active duty in a United States Military Reserve Unit will be covered on the date they return to work. Such Eligible Employees will continue to be covered under the Plan as if there had been no break in service.

Coverage must be in effect for an Eligible Employee in order for coverage to take effect for an Eligible Dependent.

Eligible Dependents who are enrolled will be covered on the same date as the Eligible Employee or the date such dependent is acquired (whichever is later), subject to the terms described in the following paragraphs. A newborn of an Eligible Employee will be covered from the moment of birth, provided the Eligible Employee already has dependent coverage; however, the newborn must be properly enrolled into the Plan as a new dependent within one (1) year following the date of birth. Claims submitted for a newborn will not be processed until the newborn is properly enrolled. If the Eligible Employee does not have dependent coverage at the time of the birth, the newborn must be properly enrolled into the Plan within thirty-one (31) days from the date of birth. A spouse will be considered an Eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a dependent of the Eligible Employee within thirty-one (31) days of the date of marriage. If a dependent is acquired other than at the time of his birth, due to a court order, decree, or marriage, that dependent will be considered an Eligible Dependent of the Eligible Employee from the date of such court order, decree, or marriage, provided this new dependent is properly enrolled as a dependent of the Eligible Employee within thirty-one (31) days of the court order, decree, or marriage. However, if a dependent child is acquired as a result of adoption, that child will be covered the day he is Placed with the adopting parents during the period before the adoption becomes final. For the purpose of this paragraph, the term "Placed" or "Placement" shall mean the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's Placement terminates upon the termination of such legal obligation. If an Eligible Dependent is not enrolled within thirty-one (31) days of becoming eligible, the Eligible Dependent will be treated as a Late Enrollee upon subsequent enrollment in the Plan, unless he is a Special Enrollee.

If an Eligible Dependent (other than a newborn child) is confined to the Hospital on his effective date, his coverage shall not become effective until the day immediately following the termination of such confinement.

If both husband and wife are employed by the Employer, the husband or wife whose birth date falls earlier in the calendar year will be covered as an Eligible Employee and may include his or her spouse as an Eligible Dependent along with any eligible dependent children. No one can be covered under this Plan as both an Eligible Employee and Eligible Dependent. Premium funding will be taken from the department of the primary covered employee.

If two Eligible Employees are married to each other, and one is covered as an Eligible Dependent of the other, if the Eligible Employee who is carrying the dependent coverage terminates, coverage can be transferred to the Eligible Dependent who is still an Eligible Employee, and no additional waiting period will apply, provided coverage is continuous. Credit will be given toward maximums, deductible, etc.

An Eligible Employee who wishes to enroll for employee or dependent coverage more than thirty-one (31) days after the Eligible Employee or Eligible Dependent is eligible for coverage may do so only during the month of December of any year; such coverage will become effective on the next following February 1st. An Eligible Employee who wishes to change medical plan options from the HMO option to this Plan, or vice-versa, must make the election during the month of December of any year; such coverage will become effective on the next following February 1st.

A person is eligible to enroll in the Plan if (1) the employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the employee requests coverage under the plan within 60 days after the termination, or (2) the employee or dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the plan within 60 days. Such coverage will be effective on the day following the date coverage is lost under Medicaid or CHIP.

This Plan will follow the ACA requirements for eligibility. This means the Employer will determine what measurement periods and stability periods (as defined by the ACA) it will follow, and based on this analysis, coverage will be allowed even if it does not meet the eligibility provisions outlined herein.

Special Enrollee with Respect to Loss of Other Coverage.

1. An Eligible Employee may be enrolled as a Special Enrollee if he is eligible (but not enrolled) for coverage under the terms of the Plan and when enrollment in the Plan was previously offered and declined by him, he was covered under another group health plan or had other health insurance coverage;

2. An Eligible Dependent may be enrolled as a Special Enrollee if he is eligible (but not enrolled) for coverage under the terms of the Plan and, when enrollment in the Plan was previously offered and declined, he was covered under another group health plan or had other health insurance coverage;

3. An Eligible Employee and Eligible Dependent(s) may be enrolled as Special Enrollees if they are eligible (but not enrolled) for coverage under the terms of the Plan and when enrollment in the Plan was previously offered and declined, they were covered under another group health plan or had other health insurance coverage.

A Special Enrollee described above is eligible to enroll in the Plan if, when enrollment in the Plan was declined, the Special Enrollee had COBRA continuation of coverage under another plan and the COBRA continuation of coverage under that other plan has since been exhausted; or if the other coverage that applied to the Special Enrollee when enrollment was declined was not under a COBRA continuation of coverage provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or Employer contributions towards the other coverage have been terminated. For the purposes of this paragraph, “loss of eligibility for coverage” includes, but is not limited to, a loss of coverage as a result of legal separation, divorce, death, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child), termination of employment, reduction in the number of hours of employment and any loss of eligibility after a period that is measured by reference to any of the foregoing. It also includes loss of eligibility when coverage is offered through an HMO, or other arrangement, in a market that does not provide benefits to individuals who no longer reside or work in a service area (whether or not within the choice of the individual); and no other benefit package is available to the individual; loss of eligibility when an individual incurs a claim that would meet or exceed a lifetime limit on all benefits (an individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until thirty [30] days after the earliest date that a claim is denied due to the operation of the lifetime limit [the 30-day period may be extended by the Plan Administrator]; loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. However, loss of eligibility does not include a loss due to failure of an individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or intentional misrepresentation of a material fact in connection with the Plan). For purposes of this paragraph, exhaustion of COBRA continuation of coverage means that an individual’s COBRA continuation of coverage ceases for any reason other than the failure of the individual to pay premiums on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan). An individual is considered to have exhausted COBRA continuation of coverage if such coverage ceases (a) due to the failure of the Employer or other responsible entity to remit premiums on a timely basis, or (b) when the individual no longer resides, lives or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation of coverage available to the individual. Proof of Special Enrollee status is required.

In the event of the enrollment of a Special Enrollee as described above, the Eligible Employee is required to enroll himself or his dependents (who are Special Enrollees), not later than thirty-one (31) days after the exhaustion or termination of the other coverage. Coverage for such Special Enrollees will be effective on the day following loss of coverage.

Special Enrollee with Respect to Certain Eligible Dependents.

1. An Eligible Employee may enroll as a Special Enrollee if he is eligible (but not enrolled) for coverage under the terms of the Plan and he would be a Covered Person in the Plan but for a prior election by him not to enroll in the Plan and he acquires an Eligible Dependent through marriage, birth, adoption or Placement for adoption.

2. An Eligible Dependent who is the spouse of the Eligible Employee may enroll as a Special Enrollee if the Eligible Dependent becomes the spouse of the Eligible Employee or the Eligible Employee and the Eligible Dependent are married and a child becomes an Eligible Dependent of the Eligible Employee through birth, adoption or Placement for adoption.

3. An Eligible Employee and an Eligible Dependent who is the Eligible Employee's spouse may enroll as Special Enrollees if the Eligible Employee would be a Covered Person in the Plan but for a prior election by the Eligible Employee not to enroll in the Plan and either the Eligible Dependent and the Eligible Employee become married or the Eligible Employee and Eligible Dependent are married and a child becomes an Eligible Dependent of the Eligible Employee through birth, adoption or Placement for adoption.

4. An Eligible Dependent who is a dependent child of the Eligible Employee may enroll as a Special Enrollee if the Eligible Dependent becomes an Eligible Dependent of the Eligible Employee through marriage, birth, adoption or Placement for adoption.

5. An Eligible Employee and an Eligible Dependent who is a dependent child of the Eligible Employee may enroll as Special Enrollees if the Eligible Employee would be a Covered Person in the Plan but for a prior election by the Eligible Employee not to enroll in the Plan and the Eligible Dependent becomes an Eligible Dependent of the Eligible Employee through marriage, birth, adoption or Placement for adoption.

In the event of the enrollment of a Special Enrollee described above, the Eligible Employee is required to enroll himself or his dependents (who are eligible to enroll as Special Enrollees), not later than thirty-one (31) days after the date of the marriage, birth, adoption or Placement for adoption. In the event of the enrollment of a Special Enrollee described in item 4 above who is a Special Enrollee for the reason of his birth, the Eligible Employee is required to enroll such Special Enrollee not later than one (1) year following the date of birth provided the Eligible Employee was already enrolled for dependent coverage. Proof of Special Enrollee status is required. Coverage for such Special Enrollees will be effective as follows:

1. Special Enrollees who enroll as Special Enrollees due to the birth, adoption or Placement for adoption of an Eligible Dependent will be Covered Persons from the moment of birth, adoption or Placement for adoption of the Eligible Dependent.

2. Special Enrollees who enroll as Special Enrollees due to marriage of an Eligible Dependent to an Eligible Employee will be Covered Persons from the date of marriage.

If a dependent is acquired other than at the time of his birth, due to a court order or decree, that dependent will be considered an Eligible Dependent of the Eligible Employee from the date of such court order or decree, provided this new dependent is properly enrolled as a dependent of the Eligible Employee within thirty-one (31) days of the court order or decree. However, if a dependent child is acquired as a result of adoption, that child will be covered the day he is Placed with the adopting parents during the period before the adoption becomes final.

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

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 PROVISION

If an Eligible Employee who is enrolled in the Plan is absent from work by reason of service in the uniformed services, the Eligible Employee and his Eligible Dependents, if any, who are enrolled in the Plan may elect to continue coverage under the Plan for a maximum period equal to the lesser of (i) the 24-month period beginning on the date on which the Eligible Employee's absence begins, or (ii) the day after the date on which the Eligible Employee fails to apply for or return to a position of employment as determined by the Employer under the federal Uniformed Services Employment and Reemployment Rights Act of 1994, as may be amended from time to time (the "USERRA"). A person who is eligible to elect to continue health-plan coverage under this provision and who so elects, is required to pay 102 percent of the cost to participate in the Plan (determined in the same manner as the cost to participate in COBRA continuation coverage), except that in the case of an Eligible Employee who performs service in the uniformed services for less than thirty-one (31) days, such person shall pay the employee contribution, if any, for such coverage. Except in the case of any Illness or Injury determined by the Secretary of Veterans' Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services, in the case of an Eligible Employee whose coverage under the Plan was terminated by reason of service in the uniformed services, any otherwise applicable exclusion under the Plan shall not be imposed in connection with the reinstatement of such coverage upon reemployment under the USERRA if that exclusion would not have been imposed under the Plan had coverage of such Eligible Employee by the Plan not been terminated as a result of such service. This paragraph applies to the Eligible Employee and to his Eligible Dependents, if any. "Service in the uniformed services" for purposes of this provision shall mean the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

TERMINATION OF COVERAGE

The coverage of any Covered Person shall terminate on the earliest of the following dates:
1. The date of termination of the Plan;
2. In the event of layoff or termination, coverage will terminate on the last day of the month for which premiums have been paid;
3. In the event of Employer approved leave of absence, coverage will continue for up to three (3) months following the date such leave of absence begins, subject to the payment of any required contribution on the part of the Eligible Employee. COBRA eligibility would start at the end of the three (3) month period.
4. In the event an Eligible Employee is unable to work as a result of an Injury or Illness arising out of employment with the Employer, and who has filed a claim for and is receiving benefits pursuant to the Ohio Workers' Compensation Act and its amendments, will be eligible to continue these benefits for up to a maximum of six (6) months. In the event such Eligible Employee is unable to

return to work by the end of this six (6) month period, the Employer will contribute one-half (1/2) of the cost of coverage with the Eligible Employee contributing the other half (1/2) of the cost of such coverage, for an additional six months. Any person qualified for these continuations must submit their portion of the monthly premium to the Auditor's office no later than the fifteenth (15th) of the month for which the premiums apply;

5. The date all coverage or certain benefits are terminated on a particular class by modification of the Plan;
6. The date the Employee fails to make any required contribution for coverage; or

MICHELLE'S LAW

If a child qualifies as an Eligible Dependent due to being a Full-Time Student, and such child is forced to take a Medically Necessary Leave of Absence from school due to a serious Illness or Injury, coverage can be continued for such Eligible Dependent. A "Medically Necessary Leave of Absence" is defined as a leave of absence from a post-secondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965) or any other change in enrollment at such an institution that begins while the student is suffering from a serious Illness or Injury; is Medically Necessary; and causes the student to lose student status for purposes of coverage under the terms of the Plan. Coverage will be continued until one year after the first day of the leave of absence or the date coverage would otherwise terminate under the terms of the Plan, whichever comes first. The Plan must receive a written certification by the treating Physician of the dependent child which states that the child is suffering from a serious Illness or Injury and that the leave of absence is Medically Necessary. The child taking the leave described herein is entitled to the same benefits as if the child had continued to be covered as a student who did not take leave. This Plan provides no greater rights than what Michelle's Law requires (nothing in this Plan is intended to expand the rights of any participant beyond the law's requirements). If Michelle's Law is amended, this Plan will follow such legislation.

THE FAMILY AND MEDICAL LEAVE ACT OF 1993

In the event that the Employer approved a leave under The Family and Medical Leave Act of 1993 (FMLA) for an Eligible Employee, that Eligible Employee may receive up to twelve (12) work weeks of continued benefits under this Plan while on such leave (provided that required contributions, if any, are made by or on behalf of that Eligible Employee). This includes all revisions made to the FMLA regulations, including the following types of leave:

1. Service member family caregiver leave that provides up to 26 weeks of protected unpaid leave in a single 12-month period to an Eligible Employee who is the spouse, child, parent or next-of-kin of a covered service member to care for the service member injured during active duty.
2. A leave of up to 12 weeks in a 12-month period as a result of any "qualifying exigency" because the Eligible Employee's spouse, child or parent is on active duty (or has been notified of an impending call to duty) in the Armed Forces in support of a "contingency operation."

Eligible Employees returning from an approved leave under the FMLA who did not continue benefits under this Plan during such leave, will not be required to satisfy a new Waiting Period upon returning from the leave. In addition, such persons will continue to be covered under the Plan as if there had been no break in service.

In the event that an Eligible Employee does not continue benefits under this Plan throughout an approved FMLA leave, the Continuation of Coverage Provision (COBRA) will apply on the earlier of:

1. The date that the Eligible Employee informs the Employer of his intent not to return from such leave; or
2. The date that the Eligible Employee does not return from such leave after the leave is over.

If Eligible Employees are taking leave under the Family and Medical Leave Act (FMLA) and they drop health coverage during the leave, any days without health coverage while on FMLA will not count towards a 63-day break in coverage. In addition, if such persons do not return from leave, the 30-day period to request special enrollment in another plan will not start before the FMLA leave ends. Therefore, when such persons are applying for other health coverage, they should tell their Plan Administrator or health insurer about any prior FMLA leave.

CONTINUATION OF COVERAGE PROVISION (COBRA)

Under certain circumstances (as outlined in this section), an Eligible Employee or Eligible Dependent may elect to continue certain benefits under this Plan, at the Covered Person's own expense, after that person is no longer eligible for coverage. This Plan provides no greater COBRA rights than what COBRA requires (nothing in this Plan is intended to expand the rights of any participant beyond COBRA's requirements). If COBRA legislation is amended, this Plan will follow such legislation.

ELIGIBILITY FOR CONTINUATION. A person who is eligible for continuation coverage is called a "Qualified Beneficiary." The events making a person eligible for continuation coverage are called "Qualifying Events."

For a covered employee to become a Qualified Beneficiary, the Eligible Employee must become ineligible for group coverage because of a Qualifying Event consisting of a termination of the Eligible Employee's employment (other than because of gross misconduct) or because of a reduction in the number of hours worked.

For a covered spouse or covered child to become a Qualified Beneficiary, the spouse or child must become ineligible for group coverage because of one of the following Qualifying Events:

1. Death of the Eligible Employee;
2. Termination of the Eligible Employee's employment (other than because of the Eligible Employee's gross misconduct) or reduction in the number of hours of employment;
3. Divorce or legal separation of the Eligible Employee from the Eligible Employee's spouse. Also, if the Eligible Employee reduces or eliminates coverage for a spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event for the Eligible Dependent spouse and/or children even though their coverage was reduced or eliminated before the divorce or legal separation;
4. The Eligible Employee becoming entitled to Medicare; or
5. A dependent child ceasing to meet the definition of "Eligible Dependent."

Provided the Eligible Employee has elected and is covered by continuation coverage, newborn children of the Eligible Employee and children Placed for adoption with the Eligible Employee on or after the date of the Qualifying Event that are properly enrolled as Eligible Dependents will be considered Qualified Beneficiaries.

TYPE OF COVERAGE TO BE CONTINUED. A Qualified Beneficiary is entitled to the same coverage that is available to other similarly situated persons covered under this Plan who have not experienced a Qualifying Event. Proof of good health will not be required.

PERIOD OF CONTINUATION. A Qualified Beneficiary may elect to continue the group coverage beyond the Qualifying Event until the earliest of the following:

1. The end of:
   a. eighteen (18) months, in a case where the Qualifying Event was a termination of employment or a reduction in hours; or
   b. thirty-six (36) months, for other Qualifying Events;
2. The date on which the Employer ceases to provide any group health plan to any Eligible Employee;
3. The date on which coverage ceases under the Plan due to the Qualified Beneficiary's failure to make timely payment of any required premium;
4. The date on which the Qualified Beneficiary first becomes, after the date of election:
   a. a covered person under any other group health plan. If the other group health plan contains an exclusion or limitation relating to a pre-existing condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for continuation coverage as long as the exclusion or limitation relating to the pre-existing condition has not been satisfied or deemed to have been satisfied; or
   b. entitled to benefits under Medicare (under Part A, Part B, or both).
5. In the case of a Qualified Beneficiary who is determined by the Social Security Administration (hereinafter SSA) to be disabled, then continuation coverage may continue for up to twenty-nine (29) months for all Qualified Beneficiaries. This extension is available only for Qualified Beneficiaries who are receiving COBRA coverage because of a Qualifying Event that was the Eligible Employee's termination of employment or reduction of hours. The disability must have started at some time before the sixty-first (61st) day after the covered employee's termination of employment or reduction of hours, and must last at least until the end of the period of COBRA coverage that would be available without the disability extension. The disability extension is available only if the Qualified Beneficiary notifies the Plan in writing of the SSA determination of disability (based on the Notification of Qualifying Event procedures outlined herein) within sixty (60) days after the latest of (1) the date of the SSA disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; (3) the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours; or (4) the date on which the Qualified Beneficiary is informed, through the Plan's summary plan description or the general COBRA notice, of his or her obligation to provide notice and the procedures for providing such notice. The Qualified Beneficiary must also provide this notice within eighteen (18) months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. Required notification procedures are outlined in the section entitled "Notification of Qualifying Event." The Employer is authorized to charge the Qualified Beneficiary an increased premium for continuation coverage extended beyond eighteen (18) months pursuant to this provision.

   In the event that the Qualified Beneficiary is determined by SSA to be no longer disabled, the Qualified Beneficiary shall notify the Employer of this determination within thirty (30) days. This notification shall be satisfied by sending a copy of the SSA letter stating that the Qualified Beneficiary is no longer considered to be disabled by SSA.

   If during extended coverage for disability (continuation of coverage months nineteen [19] - twenty-nine [29]) a Qualified Beneficiary is determined to be no longer disabled under The Act, continuation coverage shall terminate the last day of the month following thirty (30) days from the date of SSA's final determination that the Qualified Beneficiary is no longer disabled.

PREMIUM FOR CONTINUATION. The Employer will determine the amount of premium which will be charged for continuation coverage. Premium may, at the election of the payer, be made in monthly installments. Without further notice from the Employer, the Covered Person must pay the monthly premium by the last day of the period before the period for which coverage is to be effective. A thirty (30) day grace period is available before coverage will be retroactively terminated. If election of continuation coverage is made after the Qualifying Event, payment must be made (in an amount that is current, when taking the grace period into account) within forty-five (45) days of the date of election. No claim will be payable under this provision until the premium is received from, or on behalf of, the Covered Person. If mailed, the premium is considered to have been made on the date that it is postmarked. If hand-delivered, the premium is considered to have been made when it is received by the COBRA department at the Plan Supervisor's office. If the check is returned for insufficient funds, the premium will be deemed to be unpaid.

ELECTION PERIOD. A Qualified Beneficiary may elect continuation coverage during the Election Period. The Election Period means the period which:

1. Begins not later than the date on which coverage terminates under the group plan because of the Qualifying Event;
2. Is of at least sixty (60) days duration; and
3. Ends not earlier than sixty (60) days after the later of:
   a. the date coverage terminates under this Plan because of the Qualifying Event; or
   b. the date of the notice offering the election of continuation of coverage.

MULTIPLE QUALIFYING EVENTS. If during continuation coverage a Qualified Beneficiary experiences a subsequent Qualifying Event and the original Qualifying Event was termination of the Eligible Employee's employment (other than for gross misconduct) or reduction in the number of hours of the Eligible Employee's employment, then that Qualified Beneficiary may be eligible to participate in continuation coverage for up to thirty-six (36) months from the date of the original Qualifying Event.

When Plan coverage is lost due to the end of employment or reduction of the Eligible Employee's hours of employment, and the Eligible Employee became entitled to Medicare benefits less than eighteen (18) months before the Qualifying Event, COBRA coverage for the Qualified Beneficiaries (other than the Eligible Employee) who lose coverage as a result of the Qualifying Event can last up to thirty-six (36) months after the date of Medicare entitlement. For example, if an Eligible Employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the Qualifying Event (thirty-six [36] months minus eight [8] months). This COBRA coverage period is available only if the Eligible Employee becomes entitled to Medicare within eighteen (18) months before the termination or reduction of hours.

To report a subsequent Qualifying Event, the Qualified Beneficiary must send written documentation of the second Qualifying Event to the Employer within sixty (60) days of the later of (a) the occurrence of such Qualifying Event, or (b) the date on which the Qualified Beneficiary loses (or would lose) coverage as a result of the Qualifying Event, or (c) the date on which the Qualified Beneficiary is informed, through the Plan's summary plan description or the general COBRA notice, of his or her obligation to provide notice and the procedures for providing such notice.
Required notification procedures are outlined in the section entitled "Notification of Qualifying Event." If the required notification procedures are not followed, then there will be no extension of COBRA due to a second Qualifying Event.
NOTIFICATION OF QUALIFYING EVENT. The Covered Person is responsible for notifying the Employer of the occurrence of the following Qualifying Events

1. divorce or legal separation of the Eligible Employee from the Eligible Employee's spouse;
2. a dependent child ceasing to be an Eligible Dependent,
3. second qualifying events, entitling certain Qualified Beneficiaries to an extension of the COBRA maximum coverage period for up to thirty-six (36) months;
4. a Qualified Beneficiary's disability, entitling Qualified Beneficiaries to an eleven (11) month extension of the COBRA maximum coverage period for up to twenty-nine (29) months; and
5. the end of a disabled Qualified Beneficiary's disability (such that the eleven [11] month disability extension is no longer available).

Such notification must be made within sixty (60) days of the later of (a) the occurrence of such Qualifying Event; (b) the date on which there is a loss of coverage; (c) in the case of a Qualified Beneficiary's disability, the date of the SSA disability determination; or (d) the date on which the Qualified Beneficiary is informed, through the Plan's summary plan description or the general COBRA notice, of his or her obligation to provide notice and the procedures for providing such notice.
To report such Qualifying Events, the Covered Person must submit written documentation of the change to the **Deputy Auditor** within the time period noted in this paragraph. The Covered Person must include copies of the relevant paperwork (i.e. the paperwork outlining the Medicare determination of disability, a copy of the divorce decree, etc). If the notification is deficient, the Employer will request more complete information; if this request for information is not responded to within the required time period, the Notification will be rejected.
HEALTH COVERAGE TAX CREDIT. Certain individuals may be eligible for a federal income tax credit that can help with qualified monthly COBRA premium payments. Guidelines are available under the IRS.gov website.
FMLA. If an Eligible Employee takes FMLA leave and does not return to work at the end of the leave, the Eligible Employee (and the Eligible Employee's Eligible Dependents, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage within 18 months because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave). COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours.
ELECTION PROCEDURES. To elect COBRA, the Qualified Beneficiary must complete the Continuation Coverage Election Form and submit it to the Plan Supervisor. Under federal law, the Qualified Beneficiary must have sixty (60) days after the date of the COBRA election notice provided to the Qualified Beneficiary at the time of his Qualifying Event to decide whether he wants to elect COBRA under the Plan. The Continuation Coverage Election Form must be completed in writing and mailed or hand-delivered to the address shown on the form. If mailed, the election must be postmarked (and if hand-delivered, the election must be received by the individual at the Plan Supervisor's office) no later than sixty (60) days after the date of the COBRA election notice provided to the Qualified Beneficiary at the time of the Qualifying Event. If the election is not submitted within these time periods, the individual will lose his right to elect COBRA. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail. If COBRA is rejected before the due date, the Qualified Beneficiary may change his mind as long as he furnishes a completed Election Form before the due date.

DEFINITIONS OF KEY WORDS

ALCOHOLISM TREATMENT FACILITY: A part of a Hospital devoted primarily to alcoholism treatment or a facility primarily established for alcoholism treatment and specifically licensed for that purpose by the jurisdiction in which it is located.
AMBULATORY SURGICAL CENTER: Any public or private establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous Physician services and registered professional nursing services whenever a patient is in the facility, and which does not provide services or other accommodations for patients to stay overnight.
ASSIGNMENT OF BENEFITS: Authorization by the Eligible Employee for the Plan Supervisor to pay benefits directly to the provider of the service.
BRAND DRUG: A non-Generic Drug.
CLOSE RELATIVE: The spouse, parent, brother, sister, or child of the Covered Person, or the spouse of the Covered Person's parent, brother, sister, or child.
COSMETIC SURGERY: Surgery performed for the purpose of improving appearance rather than for restoring bodily function.
COVERED PERSON: The Eligible Employee or any person who is defined in this Plan as an Eligible Dependent of the Eligible Employee and is covered for benefits under this Plan.
CUSTODIAL CARE: The term "Custodial Care" means any type of service, including room and board and/or institutional service, which is designed essentially to assist a Covered Person, whether disabled or not, in the activities of daily living. Such services include assistance in walking or getting in and out of bed, bathing, dressing, feeding, preparation of special diets and supervision over medication which can normally be self-administered.
DENTAL HYGIENIST: Someone who is currently licensed to practice dental hygiene and is acting under the supervision and direction of a Dentist.

DENTIST: A duly licensed Dentist practicing within the scope of the dental profession and any other Physician furnishing any dental services which such Physician is licensed to perform.

DURABLE MEDICAL EQUIPMENT: Equipment that meets all of the following tests:

1. Is able to withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is not generally useful to a person in the absence of Illness or Injury; and
4. Is covered under Medicare guidelines.

ELIGIBLE DEPENDENTS: The Eligible Employee's spouse, unless divorced, and all children from birth to twenty-six (26) years of age. The term “spouse” will mean one that is recognized as a spouse under the Internal Revenue Code. The term "children" will include only natural children; stepchildren; legally adopted children (including children Placed with the adopting parents during the period before the adoption becomes final); or children for whom the Eligible Employee is the child's legal guardian or has legal custody. Such children do not need to live with the Eligible Employee or to be financially dependent upon the Eligible Employee for support. Such children do not need to be Full-Time Students, and they are also eligible if they are married and/or employed. Dependents of such children will not be eligible for coverage.

A child who is physically or mentally incapable of self-support upon attaining the age of twenty-six (26) may be considered an Eligible Dependent while remaining incapacitated, unmarried and continuously covered under the Plan. To continue a child under this provision, proof of incapacity may be required from time to time.

The term "Eligible Dependent" shall not include any dependent who is covered as an Eligible Employee. Also, if both parents are employed by the Employer, children will be covered only as Eligible Dependents of one parent.

In order for a child to be covered under these provisions, the Eligible Employee must also be enrolled for coverage.

If a child was covered under the Employer’s previous definition of Eligible Dependents but not under the definition shown above, he will remain covered up to the age limits shown here.

ELIGIBLE EMPLOYEES: Employees who were employed prior to February 1, 2002 and who are regularly scheduled to work at least 24 hours per week are eligible to be covered by the Plan. Employees who were employed on or after February 1, 2002 and who are in active pay status at least 30 hours per week on a regularly scheduled basis are eligible to be covered by the Plan. Elected officials and County Commissioners are also included in this definition. Seasonal, intermittent and temporary employees are not eligible for benefits.

EMERGENCY CARE: Treatment for a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. placing the health of the individual or, with respect to a pregnant woman, the health of her unborn child, in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part.

EMERGENCY HOSPITAL ADMISSION: An Emergency Hospital Admission is defined as an admission for Inpatient Hospital confinement for a condition which, unless immediately treated only on an Inpatient basis, would jeopardize the patient's life or cause serious impairment to the patient's bodily functions.

EMPLOYER: The Employer is Jefferson County.

ESSENTIAL HEALTH BENEFITS: Such benefits include ambulatory patient services, emergency services, hospitalization, maternity and newborn care; mental health and substance disorders; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services, chronic-disease management and pediatric services, including oral and vision care.

EXPERIMENTAL OR INVESTIGATIONAL: One or more of the following is true of a treatment, procedure, device, drug, or medicine:

1. It cannot be lawfully marketed without U.S. Food and Drug Administration approval; and approval for marketing for the condition treated has not been given at the time the device, drug or medicine is furnished;
2. Reliable evidence shows that to determine its maximum tolerated dose, toxicity, safety, efficacy (or efficacy as compared with the standard means of treatment or diagnosis):
    a. It is undergoing phase I, II, or III clinical trials or is under study; or
    b. further clinical trials or studies are needed, according to the experts’ consensus of opinion.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; or the written protocol or written informed consent used by the treating facility (or by another facility studying substantially the same treatment, procedure, device, drug or medicine).

Experimental or Investigational shall also mean:

1. Any treatments, services, supplies or related expenses that are educational or provided primarily for research; or
2. Treatments, procedures, devices, drugs or medicines or other expenses relating to the transplant of non-human organs.

FREESTANDING BIRTHING FACILITY: The term "Freestanding Birthing Facility" means an institution or facility, either free standing or as part of a Hospital with permanent facilities, equipped and operated for the primary purpose of performing maternity deliveries and to which a patient is admitted to and discharged from within a twenty-four (24) hour period.

FREESTANDING DIALYSIS FACILITY: Any freestanding establishment with permanent facilities that are equipped and operated primarily for the purpose of performing peritoneal, renal or other kinds of dialysis, with continuous Physician services and registered professional nursing services whenever a patient is in the facility. Such facility must be accredited as a dialysis facility by the Healthcare Financing Administration (HCFA). For the purpose of this Plan, a facility meeting these requirements will be considered a Freestanding Dialysis Facility by whatever actual name it may be called; however, a facility located on or in conjunction with or in any way made a part of a regular Hospital shall be excluded from the terms of this definition.

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

GENERIC DRUG: A drug or medicine which is produced and sold under the chemical name or a shortened version; is approved by the U.S. Food and Drug Administration as safe and effective; is produced after the original patent expires; is produced by a company different from the one that first patented the chemical formulation; and costs less than the product produced by the company that first patented the chemical formulation.

HOME HEALTH CARE AGENCY: The term "Home Health Care Agency" means only a public or private agency or organization, or a sub-division thereof, that (a) is primarily engaged in providing skilled nursing and other therapeutic services, (b) has policies established by associated professional personnel, including one or more Physicians and one or more Registered Professional Nurses (R.N.), to govern the services provided under the supervision of such a Physician or nurse, (c) maintains clinical records on all patients, and (d) in cases where the applicable state or local law provides for the licensing of agencies or organizations of this nature, the latter are licensed or approved by the state or local law as meeting the standards established for such licensing. In no event will the term "Home Health Care Agency" include one which is engaged primarily in the care and treatment of mental disease.

HOSPICE: An agency that provides counseling and incidental medical services and may provide room and board to a terminally ill person and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval;
2. It provides 24-hour-a-day, 7-day-a-week service;
3. It is under the direct supervision of a duly qualified Physician;
4. It is an agency that has as its primary purpose the provision of Hospice services;
5. It has a full-time administrator;
6. It maintains written records of services provided to the patient;
7. Its employees are bonded, and it provides malpractice and malplacement insurance; and
8. It is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law.

HOSPITAL: An institution engaged primarily in providing medical care and treatment of ill and injured persons on an Inpatient basis at the patient's expense and which in the opinion of the Plan Administrator meets the tests set forth in 1 or 2 below:

1. It is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations.
2. It meets all the following tests:
   a. it maintains, on the premises, diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of ill and injured persons by or under the supervision of a staff of duly qualified Physicians; and
   b. it continuously provides, on the premises, 24-hour-a-day nursing service by or under the supervision of Registered Professional Nurses (R.N.); and
   c. it is operated continuously with organized facilities for operative surgery on the premises.

The term "Hospital" does not include a hotel, rest home, nursing home, convalescent home, facility for Custodial Care of the mentally ill or of the aged, or an institution primarily for the treatment of drug addiction or alcoholism.

ILLNESS: A bodily disorder, disease, physical Illness, mental infirmity, or functional nervous disorder of a Covered Person.

INJURY: An accidental physical Injury to the body caused by unexpected external violent means. A strain will not be considered due to an Injury.

INPATIENT: A Covered Person shall be considered to be an "Inpatient" if he is admitted to a Hospital, Hospice, or any other covered facility for treatment, and charges are made for room and board to the Covered Person as a result of such treatment. A Covered Person will also be considered to be an "Inpatient" if the confinement is a Partial Confinement as defined herein, or if he is in observation status for a period of twenty-four (24) hours or more.

LATE ENROLLEE: An Eligible Employee or Eligible Dependent who is not enrolled in the Plan on the earliest date possible in accordance with the requirements of the Eligibility and Effective Date of Coverage provisions of this Plan, unless such person is a Special Enrollee.

MEDICALLY NECESSARY: "Medically Necessary" means that there is an Illness or Injury which requires treatment, and the confinement, service or supply used to treat the Illness or Injury is:

1. Required;
2. Generally professionally accepted as the usual, customary, and effective means of treating the Illness or Injury in the United States; and
3. Approved by regulatory authorities such as the Food and Drug Administration and any other such organizations.

Diagnostic x-rays and laboratory tests are "Medically Necessary" when:

1. Performed due to definite symptoms of Illness or Injury; or
2. They reveal a need for treatment.

NURSE-MIDWIFE: A person certified to practice as a Nurse-Midwife, who has an active license as a registered nurse granted by a board of nursing, and who has completed a state approved program for the preparation of Nurse-Midwives.

OPTOMETRIST: A person duly licensed to practice optometry by the governmental authority having jurisdiction over the licensing and practice of optometry in the locality where the service is rendered.

OUTPATIENT: A Covered Person shall be considered to be an "Outpatient" if he receives medical care, treatment, services or supplies at a clinic, a Physician's office, a Hospice, or a Hospital if not considered an Inpatient at that Hospital (as determined by this Plan's definition of Inpatient).

PARTIAL CONFINEMENT: Partial Confinement means treatment at a covered facility for at least three (3) hours, but no more than twelve (12) hours, in any twenty-four (24) hour period, with a duration of at least three (3) consecutive days.

PHYSICIAN: A person duly licensed under the governing authority to perform the services rendered and covered for benefits under the Plan. Should such person be other than a Medical Doctor, Doctor of Osteopathy, audiologist or Doctor of Dental Surgery, the statutes of the applicable jurisdiction require that such person be recognized as a Physician to the extent that he is performing services within the scope of his license. For purposes of this Plan, a licensed professional counselor will be considered as a Physician, and a social worker working under the supervision of a psychologist or psychiatrist will be considered as a Physician. In accordance with federal legislation, this Plan shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law.

PLAN: The Plan is The Jefferson County Employee Health Plan.

PLAN ADMINISTRATOR: The Plan Administrator is the Employer, which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan connected services. The Plan Administrator is also the Plan Sponsor and named fiduciary.

PLAN SPONSOR: The Plan Sponsor is the Employer.

PLAN SUPERVISOR: The company providing services to the Employer in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it. The Plan Supervisor is Self-Funded Plans, Inc.

PLAN YEAR: The Plan Year runs from February 1st to January 31st of each year.

PREVENTIVE/MAINTENANCE CARE: Any care that seeks to prevent Illness, prolong life, promote health, enhance the quality of life and/or maintain the optimum state of health after the patient has reached a maximum level of recovery.

REASONABLE AND CUSTOMARY CHARGE (R & C): If services are rendered by a PPO Provider, the allowable amount established by the PPO will be considered the Reasonable and Customary Charge.

If services are rendered by a non-PPO provider, the Reasonable and Customary Charge for facility based services is equal to two hundred percent (200%) of the amount otherwise payable to the provider under the Medicare program as administered by the Center for Medicare and Medicaid Services (CMS). In the event a Medicare allowable amount cannot be determined for a given provider or service, the Reasonable and Customary Charge for services is based on a relative value system for the types of services performed, taking into consideration the geographic areas where the services are performed, as well as the fees being charged within those geographic areas. The Reasonable and Customary Charge for supplies is based on a relative value system for the types of supplies provided, taking into consideration the geographic areas where the supplies are provided, as well as the fees being charged within those geographic areas. The calculation for the Reasonable and Customary Charge pursuant to this section takes into consideration any unusual circumstances or complications which require additional time, skill or experience in connection with the particular service or procedure. This Plan will allow the 50th percentile of the Reasonable and Customary tables.

If services are rendered by a non-PPO provider, the Reasonable and Customary Charge for all other services is equal to one hundred and fifty percent (150%) of the amount otherwise payable to the provider under the Medicare program as administered by the Center for Medicare and Medicaid Services (CMS). In the event a Medicare allowable amount cannot be determined for a given provider or service, the Reasonable and Customary Charge for services is based on a relative value system for the types of services performed, taking into consideration the geographic areas where the services are performed, as well as the fees being charged within those geographic areas. The Reasonable and Customary Charge for supplies is based on a relative value system for the types of supplies provided, taking into consideration the geographic areas where the supplies are provided, as well as the fees being charged within those geographic areas. The calculation for the Reasonable and Customary Charge pursuant to this section takes into consideration any unusual circumstances or complications which require additional time, skill or experience in connection with the particular service or procedure. This Plan will allow the 50th percentile of the Reasonable and Customary tables.

In lieu of the above, the Plan Supervisor may also negotiate fees with a non-PPO provider, and the negotiated amount will be considered the Reasonable and Customary Charge.

SEMI-PRIVATE ROOM RATE: The charge made by a Hospital for a room containing two (2) or more beds, including such charges in the intensive care unit.

SKILLED NURSING FACILITY: An institution which is licensed to provide, on an Inpatient basis, for persons convalescing from an Injury or Illness, professional nursing services and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities. Also called a convalescent facility.

TOTAL DISABILITY: In the case of an Eligible Employee, the inability to perform the duties of his regular occupation and the inability to perform any other work for compensation or profit. In the case of an Eligible Dependent, the inability to perform the normal duties of a person of the same sex and of comparable age.

URGENT CARE FACILITY: A free-standing facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse, and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, a facility located on or in conjunction with or in any way made a part of a regular Hospital shall be excluded from the terms of this definition.

WAITING PERIOD: A continuous period of sixty (60) days commencing on the first day a person is an Eligible Employee.

MEDICARE PROVISION

For those Eligible Employees (who have Plan coverage by virtue of their current employment status as defined in Medicare) or spouses of Eligible Employees (who have Plan coverage by virtue of the Eligible Employee's employment status as defined in Medicare), who are age sixty-five (65) or older and who are entitled to benefits under Medicare, this Plan will pay primary benefits, unless the Eligible Employee or spouse refuses coverage under this Plan. If such Eligible Employee or spouse refuses coverage under this Plan, Medicare will be the sole source of benefits. Eligible Employees or spouses of Eligible Employees who have enrolled in this Plan are deemed to have accepted coverage under this Plan until the Plan Administrator receives a written election indicating that an Eligible Employee or spouse of an Eligible Employee refuses coverage under this Plan. Any charges which are not paid under this Plan should be submitted to Medicare as secondary payor. For COBRA Qualified Beneficiaries who are age sixty-five (65) or older and who are entitled to benefits under Medicare, this Plan will pay secondary benefits.

For those Eligible Employees (who have Plan coverage by virtue of their current employment status as defined in Medicare), or Eligible Dependents (who have Plan coverage by virtue of a family member's current employment status as defined in Medicare), who are entitled to benefits under Medicare because of total disability (and who are not or could not be entitled to benefits under Medicare on the basis of End Stage Renal Disease), this Plan will pay primary benefits, unless the Eligible Employee or Eligible Dependent refuses coverage under this Plan. If such Eligible Employee or Eligible Dependent refuses coverage under this Plan, Medicare will be the sole source of benefits. Eligible Employees or Eligible Dependents who have enrolled in this Plan are deemed to have accepted coverage under this Plan until the Plan Administrator receives a written election indicating that an Eligible Employee or Eligible Dependent refuses coverage under this Plan. Any charges which are not paid under this Plan should be submitted to Medicare as secondary payor. For COBRA Qualified Beneficiaries who are entitled to benefits under Medicare because of total disability (and who are not or could not be entitled to benefits under Medicare on the basis of End Stage Renal Disease), this Plan will pay secondary benefits.

For the purpose of this paragraph, the time that a person is an Eligible Employee or Eligible Dependent is added to the time that a person is a COBRA Qualified Beneficiary to determine whether the Plan pays primary benefits or secondary benefits. For those Eligible Employees or Eligible Dependents who are entitled to benefits under Part A of Medicare solely on the basis of End Stage Renal Disease the Plan will pay primary benefits during the 30-month period beginning on the earlier of: the first month in which the Eligible Employee or Eligible Dependent becomes entitled to benefits under Part A of Medicare; or the first month in which the Eligible Employee or Eligible Dependent would have been entitled to benefits under Part A of Medicare if such person had filed an application for such benefits. After the expiration of such 30-month period, Medicare benefits will be primary and this Plan will pay secondary benefits.

For those Eligible Employees or Eligible Dependents who are entitled to benefits under Medicare solely on the basis of End Stage Renal Disease and who subsequently become entitled to benefits under Medicare for the reason of attaining age sixty-five (65) or for a disability other than End Stage Renal Disease, the Plan will pay in accordance with the End Stage Renal Disease provisions stated above.

For those Eligible Employees or Eligible Dependents who are entitled to benefits under Medicare on the basis of attaining age sixty-five (65) or because of disability (other than End Stage Renal Disease), and who subsequently become entitled to benefits under Medicare on the basis of End Stage Renal Disease, the End Stage Renal Disease provisions stated above will apply but only if, prior to such entitlement to benefits under Medicare on the basis of End Stage Renal Disease, the Plan was to pay primary benefits and Medicare was to pay secondary benefits under other provisions of the Plan.

For those Eligible Employees or Eligible Dependents who are not entitled to benefits under Medicare on the basis of attaining age sixty-five (65) or because of disability (other than End Stage Renal Disease), and who become entitled to benefits under Medicare on the basis of attaining age sixty-five (65) or because of disability (other than End Stage Renal Disease) and, simultaneously, End Stage Renal Disease, the End Stage Renal Disease provisions stated above will apply.

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

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent payment of benefits which exceed expenses. It applies when any person who is covered under this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always either pay its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. Only the amount paid by the Plan will be charged against the Plan maximums. Medical, Dental and Vision Benefits are subject to this provision. When any person is eligible for coverage under two or more plans, it is necessary to determine which plan is primary and which plan is secondary. The following rules are used to determine the primary carrier:

1. A plan which does not have a non-duplication of benefits or coordination of benefits provision will be the primary carrier;
2. If all the plans have Coordination of Benefits provisions, a plan is primary if it covers the person as an employee, and secondary if it covers the person as a dependent;
3. The primary plan is the plan that covers the person as an active, full-time employee, or that employee's dependent. The secondary plan is the plan that covers that person in a status other than as an active, full-time employee, or that employee's dependent;
4. If a person is covered as a dependent child under more than one (1) plan:
    a. the plan of the parent whose birthday falls earlier in the year is the primary plan;
    b. if the father and mother have the same birthday, the plan covering the parent longer is the primary plan;
    c. if the other plan's provisions for coordination of benefits do not follow the rule of this plan (as stated in 4a & b), then the rules for coordination of benefits of the other plan shall determine the order of benefits;
    d. if more than one plan covers a person as a dependent child of divorced or separated parents, benefits for the child will be determined by the specific terms of the Court decree. If the Court decree states which parent is responsible for the health care expenses of the child then that parent's plan shall be primary. If there is no Court decree or the Court decree is silent as to which parent is responsible for the health care expenses of the child, or if the Court decree is not being followed by the parent who is supposed to be providing coverage, then the plan that will pay primary benefits will be determined in the following order:

i. the plan of the parent with custody of the child;
ii. the plan of the spouse of the parent with custody of the child;
iii. the plan of the parent without custody of the child.

5. When the above rules do not establish an order of benefit determination, the benefits of a Plan which has covered the person for the longer period of time shall be determined before the benefits of a Plan which has covered the person the shorter period of time.
6. The Covered Person's benefits under automobile "no fault" and "fault" insurance, including uninsured and underinsured motorist coverage, and medical payment coverage is determined before the benefits of this Plan.

This Plan will coordinate benefits with any of the following types of coverage:

1. Group, blanket, franchise, or individual insurance coverage;
2. Hospital services payment plans, medical services prepayment plans, health maintenance organizations, or other group prepayment coverage;
3. Any coverage under labor-management trustee plans, union welfare plans, employee organization plans, or employee benefit organization plans;
4. Any coverage provided by automobile "No Fault" legislation or any coverage provided by the Social Security Act or any other statute, including but not limited to Medicare;
5. Any Employer-sponsored non-insured employee benefit plans; and
6. Any coverage for students which is sponsored by, or provided through, a school or other educational institution.

SUBROGATION

By enrolling for coverage under the Plan, Covered Persons understand and agree that if Illness, Injury or other condition to a Covered Person is caused by an act or omission of a third party or the Covered Person, the Plan may, if the requirements of this section are satisfied, advance benefits for medical expenses incurred as a consequence of the act or omission. In addition, Covered Persons agree that if any payments are made to or on behalf of a Covered Person and such payments have arisen as a result of an Injury, Illness or other condition for which the Covered Person has, or may have, or asserts any claim or right of recovery (including, without limitation, claims for pain and suffering, loss of consortium, consequential, punitive, exemplary or other damages) against a third party or parties, then any benefits advanced by this Plan for such medical expenses shall be made on the condition and with the agreement and understanding that the Covered Person shall reimburse the Plan to the extent of (but not exceeding) any amount or amounts recovered by or on behalf of the Covered Person (including the Covered Person's estate) from any third party by way of settlement or in satisfaction of any judgment relating to said claim. For example, should the Plan advance benefits totaling $90,000 on behalf of a Covered Person involved in a subrogation matter, and that Covered Person receive a full and final settlement in the amount of $60,000, the Plan would be entitled to recover the $60,000 amount which, assuming no other source of recovery, would serve to fully satisfy the Plan's subrogation interest in that matter, regardless of any other expenses, such as attorneys' fees or privately paid medical costs which are not covered by Plan provisions. The Plan shall maintain a lien on any such recovery and be entitled to reimbursement in full in accordance with this section, irrespective of whether the settlement monies received by the Covered Person leave a Covered Person fully compensated or "made whole" for all or any of said claims. The Plan shall be entitled to such reimbursement from first dollar recovery amounts received by the Covered Person and as such shall specifically have priority over any other interests including, without limitation, any unpaid medical expenses not submitted through the Plan for any party, attorneys' fees (regardless of whether they are considered contingent or hourly)and legal costs and shall supersede the Covered Person's right to be made whole. As security for the Plan's rights to such reimbursements, the Plan shall be subrogated to all claims, demands, actions or rights of recovery of the Covered Person against any third party or parties (or their insurers) to the extent of any and all benefits advanced by the Plan. The Covered Person agrees to cooperate with and assist the Plan in obtaining or providing any information or document production necessary to support the subrogation rights of the Plan. Any Covered Person who takes any action prejudicing or otherwise impairing the subrogation rights of the Plan shall be liable to the Plan for any losses to the Plan caused by such action, such as withholding information from the Plan regarding third party insurance company's contact information, policy limits or concealing development of any legal proceedings or settlements between legal representatives of Covered Persons and any third parties. Any action prejudicing or otherwise impairing the subrogation rights of the Plan made by the Covered Person shall also terminate the Plan's obligation to advance benefits to or on behalf of the Covered Person. The Plan Supervisor shall withhold payments of claims made under this Plan, to the extent that the Plan Supervisor has reason to believe that said claims arise as a result of any act of a third party, until the Covered Person or the Covered Person's legal representative executes the forms required by the Plan without alteration or modification. The subrogation rights of the Plan, as set forth in this section, shall also apply to payments made by the Covered Person's own insurance or his own or any auto insurance, including, but not limited to, medical payments coverage, any excess, umbrella, uninsured/underinsured motorists coverage, personal protection policies issued under 'no-fault' coverage provisions, and/or any other applicable insurance coverage (with the exception of payment for property damage). For purposes of this section and any Agreement executed pursuant hereto, the term Covered Person shall include the dependents, heirs, guardians, executors or other representatives of the Covered Person. For purposes of this section and any Agreement executed pursuant hereto, the spouses, children and other dependents as Covered Persons under the Plan are third party beneficiaries under the Plan and therefore subject to the same duties and obligations as employees who are Covered Persons under the Plan. The Plan shall have no obligation to share the cost of, or pay any part of, the Covered Person's attorney fees and costs incurred in obtaining any recovery against the third party. The Plan retains the right, at its sole discretion, to commence litigation against third parties, file claims or take any other action on behalf of the Covered Person, respective to the Plan's advanced benefits, should the Covered Person not commence litigation, file claims or take appropriate action within a reasonable period of time. Covered Persons must notify the Plan of the Covered Person's claim at the time the Covered Person files a lawsuit to recover damages or 90 days prior to the expiration of the statute of limitations, whichever is sooner. Should the Covered Person fail to comply with the requirements of this section, the Covered Person shall pay the Plan's reasonable collection costs and attorney fees incurred in collecting amounts due under the Plan.

MISCELLANEOUS PROVISIONS

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION
The Plan may, without the consent of or notice to any person, release to or obtain from any insurance company or any other party, any information which the Plan deems relevant for the purpose of applying and implementing the terms of the Plan. Any person claiming benefits under the Plan shall furnish to the Plan such information as may be necessary to implement this provision.

FACILITY OF PAYMENT
Whenever payments that should have been made under this Plan were made by another plan, this Plan shall have the right, exercisable alone and at its sole discretion, to reimburse the other plan in the amount that would have been paid by this Plan. Such reimbursement shall be deemed payment for covered services and the Plan shall be fully discharged from liability.

RIGHTS OF RECOVERY
Whenever payments have been made by the Plan in an amount which exceeds the maximum amount of payment allowed under the Plan at that time, the Plan shall have the right to recover such payment irrespective of to whom paid, to the extent of such excess from among one (1) or more of the following parties: any persons to whom or with respect to whom such payments were made, any insurance companies, or any other organizations or persons.

DISCRETIONARY AUTHORITY
The Plan Administrator shall have the discretionary power and authority to: determine eligibility for benefits; interpret or construe the terms of the Plan and any other writing affecting the establishment or operation of the Plan; determine questions of fact which arise in connection with the Plan; and decide all matters arising under the Plan, based on the applicable facts and circumstances.

DECLARATORY JUDGMENT
In the event that a question of coverage is presented to a court of competent jurisdiction through a declaratory judgment, and the court rules that the Plan is responsible for providing coverage, then the Plan will cover the expense to the extent permitted by all other Plan provisions.

PLAN MODIFICATION AND AMENDMENT
The Plan Sponsor may modify or amend the Plan from time to time at its sole discretion and the amendments or modifications which affect the Plan members will be communicated to them. Any Plan amendment shall be by a written instrument signed by a representative or representatives of the Employer who have been authorized by resolution or other appropriate authority to amend the Plan and shall become effective as of the date specified in the instrument. A copy of such instrument shall be furnished to the Plan Administrator and any outside provider of Plan administration services.

PLAN TERMINATION
The Plan Sponsor may terminate the Plan at any time. Any termination of the Plan will be communicated to plan members.

ASSIGNMENT OF BENEFITS
In the event a Covered Person has executed an Assignment of Benefits, the Plan shall pay benefits directly to the provider of service. If the Plan receives notification from a provider that the provider has the Covered Person's authorization to assign benefits on file, then that shall be acceptable notice to the Plan that an Assignment of Benefits has been executed.

PROOF OF CLAIMS (Filing of Claims)
Written proof of claims must be furnished to the Plan by or on behalf of the Covered Person or the provider within twelve (12) months after the date such claims are incurred (a claim shall be considered incurred on the date the service is rendered or the supply is received). Proof of claims includes the following:

An itemized bill for the service or supply must be furnished to the Plan. An itemized bill for all professional services must include a diagnosis (ICD) code and a Current Procedural Terminology (CPT) code for each service provided. The bill should be sent to the address shown on the ID card.

The Eligible Employee must complete one (1) Employee Statement on a frequency to be determined by the Plan Administrator.

If the Plan Administrator or Plan Supervisor requests information from the Eligible Employee, the Eligible Employee must furnish such information as requested.

If the Plan Administrator or Plan Supervisor requests information from a provider and the provider does not furnish the requested information, the Eligible Employee will be required to obtain the requested information and furnish it to the Plan Administrator or Plan Supervisor.

All of the above requirements must be met within the twelve (12) month time period in order for the claim to be considered.

PAYMENT OF CLAIMS
All Plan benefits are payable to the Eligible Employee, unless the Eligible Employee has assigned such benefits to the provider of services. If the Plan Administrator determines that any Eligible Employee entitled to Plan Benefits is incompetent, the Plan Administrator may cause all Plan benefits thereafter becoming due to such Eligible Employee to be made to any other person for his benefit, without the responsibility to follow the application of amounts so paid. Any benefits otherwise payable to an Eligible Employee following the date of death of such Eligible Employee shall be paid to his or her spouse, or, if there is no surviving spouse, to his or her estate. Payments made pursuant to this section shall completely discharge the Plan and the Plan Administrator.

APPEAL PROCEDURES
If a claim is denied in whole or in part, the Plan Supervisor will provide written notification to the Eligible Employee in the same fashion as reimbursement for a claim. A claim worksheet will be provided by the Plan Supervisor, showing the calculation of the total amount payable, charges not payable, and the reason. If additional information is needed for payment of a claim, the Plan Supervisor will request such information.

If a claim is denied in whole or in part, the Eligible Employee may appeal the decision. The Eligible Employee or his authorized representative may examine pertinent documents (except for information in the file which the Physician does not wish made known to the claimant), and the Eligible Employee may send a written letter of appeal outlining his position. The written appeal must be filed with the Plan Supervisor within sixty (60) days after denial is received; however, it is suggested that it be filed promptly whenever possible. Upon receipt of the written appeal, the Plan Supervisor will furnish copies of all relevant documents to the Plan Administrator for review and final decision. A decision will be made within sixty (60) days unless special circumstances require extension, in which case such decision will be rendered no later than 120 days. A letter will be sent to the Eligible Employee (or his authorized representative) which

references the pertinent Plan provisions supporting the decision. Unless the "Independent Review Provisions" apply, this decision will be final.

ACTIONS

No action at law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor shall such action be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

CONFORMITY OF LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

CHANGE IN PLAN PROVISIONS

Any change in Plan provisions will apply only to expenses incurred on or after the effective date of the Plan change. If, on the effective date of a Plan change, a Covered Person is confined in a Hospital, the Plan provisions in force before the effective date of the change will continue in force until, in the case of the Eligible Employee, the Eligible Employee returns to work for one full day, or, in the case of an Eligible Dependent, the Eligible Dependent is released from the Hospital.

PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract between the Plan Sponsor and any employee or to be a consideration for, or an inducement or condition of, the employment of an employee. Nothing in the Plan shall be deemed to give an Employee the right to be retained in the service of the Plan Sponsor or to interfere with the right of the Plan Sponsor 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 Sponsor with the bargaining representatives of any employee.

BOOKLETS

The Plan Sponsor has issued herewith to each covered Eligible Employee under this Plan an individual booklet which summarizes the benefits to which the person may be entitled, to whom benefits may be payable, and the provisions of the Plan principally affecting the Eligible Employee and his Eligible Dependents. In the event of any discrepancies between the booklet and the plan document, the plan document will govern.

FORM OF WORDS

A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the content clearly indicates otherwise.

EXAMINATION

The Plan Administrator, at the Plan's expense, shall have the right and opportunity to have the Covered Person examined whose Injury or Illness is the basis of a claim hereunder when and so often as it may reasonably require during the pendency of claim hereunder. If the Plan requires that the Covered Person be examined by a Physician of the Plan's choice, and the Covered Person does not comply with this request, the Plan has the right to deny benefits for the claim in question. The Plan Administrator also has the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

WORKERS' COMPENSATION NOT AFFECTED

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

MEDICAL CHILD SUPPORT ORDERS

The Plan will follow the applicable state requirements, if any, for orders issued by: (1) a court of competent jurisdiction, or (2) through an administrative process established under state law that has the force and effect of law under applicable state law, that establishes a parent's obligation to provide health coverage to children who are Eligible Dependents and who are the subject(s) of such order, provided such order does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan.

MEDICAID PROVISION

Payments for benefits will be made in accordance with any assignment of rights made by or on behalf of a Covered Person as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of such Act as in effect on August 10, 1993. The fact that an Eligible Employee or Eligible Dependent is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act will not be taken into account for determining eligibility or determining or providing benefits under this Plan. To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act and this Plan would provide a benefit for those items or services constituting such assistance, payment for benefits under this Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to the Covered Person to such payment for such items or services.

INDEPENDENT REVIEW PROVISIONS

Ohio Superintendent of Insurance Review of Plan Coverage

In the event that a Covered Person has been denied coverage of a health care service on the grounds that the service is not a service covered under the terms of the Plan, and the Covered Person has exhausted the Plan's appeal procedures, and the Covered Person has submitted a written request to the Ohio Superintendent of Insurance to review the denial, and the Ohio Superintendent of Insurance notifies the Plan that the service is a service covered under the terms of the Plan, then the Plan will cover such service. If the Ohio Superintendent of Insurance notifies the Plan that making the determination requires the resolution of a medical issue, the Covered Person may request an external review of the denial in accordance with the "External Review of Medical Necessity" provision below or the "External Review for Terminal Illness" provision below.

External Review of Medical Necessity

An external review of medical necessity shall mean a review conducted in accordance with applicable law by an independent review organization assigned by the Ohio Superintendent of Insurance.

A Covered Person (or the Covered Person's parent, guardian, or other person authorized to act on behalf of the Covered Person with respect to health care decisions) may request an external review of medical necessity provided:

1. the request is in writing;
2. the Plan has denied, reduced, or terminated coverage for what would be a covered health care service except that the Plan has determined that the health care service is not Medically Necessary;
3. the proposed service, plus any ancillary services and follow-up care, will cost the Covered Person more than $500 if the proposed service is not covered by the Plan; and

4. the request is accompanied by written certification from the Covered Person's provider or the health care facility rendering the health care service to the Covered Person that the proposed service, plus any ancillary services and follow-up care, will cost the Covered Person more than $500 if the proposed service is not covered by the Plan.

A Covered Person need not be afforded an External Review of Medical Necessity if:

1. the Ohio Superintendent of Insurance has determined that the health care service is not a service covered under the terms of the Plan pursuant to the Ohio Superintendent of Insurance Review of Plan Coverage provision above;
2. the Covered Person has failed to exhaust the appeal procedures of the Plan; or
3. the Covered Person has previously been afforded an external review of medical necessity for the same denial of coverage and no new clinical information has been submitted to the Plan.

The Plan may deny a request for an external review of medical necessity if the request is made later than sixty (60) days after receipt by the Covered Person of notice from the Ohio Superintendent of Insurance pursuant to the Ohio Superintendent of Insurance Review of Plan Coverage provision above, that making a determination on the denied, reduced or terminated coverage for the health care service requires the resolution of a medical issue.

An external review of medical necessity may also be requested by the Covered Person's provider or the health care facility rendering health care services to the Covered Person provided the provider or health care facility obtains the prior consent of the Covered Person and satisfies the other requirements for making the request.

In the event that a Covered Person's provider certifies that the Covered Person's condition could, in the absence of immediate medical attention result in:

1. placing the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or the unborn child, in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part,

the Covered Person may request an expedited external review of medical necessity.

If an expedited external review of medical necessity is permitted, the Covered Person does not have to provide evidence that the proposed service, plus any ancillary services and follow-up care, will cost the Covered Person more than $500 if the proposed service is not covered by the Plan or the written certification from the Covered Person's provider or the health care facility rendering the health care service to the Covered Person that the proposed service, plus any ancillary services and follow-up care, will cost the Covered Person more than $500 if the proposed service is not covered by the Plan. An expedited external review of medical necessity may be requested orally or by electronic means provided that written confirmation of the request is submitted to the Plan not later than five (5) days after the request is made.

The Plan will provide any coverage determined by the independent review organization's decision to be Medically Necessary, subject to the other terms, limitations, and conditions of the Plan. The cost of the external review of medical necessity shall be paid by the Plan.

External Review for Terminal Illness

An external review for terminal Illness shall mean a review conducted in accordance with applicable law by an independent review organization assigned by the Ohio Superintendent of Insurance.

A Covered Person may request an external review for terminal Illness provided:

1. the request is in writing;
2. the Covered Person has a terminal condition that, according to the current diagnosis of the Covered Person's Physician, has a high probability of causing death within two (2) years;
3. the Covered Person requests a review not later than sixty (60) days after receipt by the Covered Person of notice from the Ohio Superintendent of Insurance pursuant to the Ohio Superintendent of Insurance Review of Plan Coverage provision above, that making a determination requires the resolution of a medical issue;
4. the Covered Person's Physician certifies that the Covered Person has a terminal condition that, according to the current diagnosis of the Covered Person's Physician, has a high probability of causing death within two (2) years and any one of the following is applicable:
   a. standard therapies have not been effective in improving the condition of the Covered Person;
   b. standard therapies are not medically appropriate for the Covered Person; or
   c. there is no standard therapy covered by the Plan that is more beneficial than the therapy described in provision 5. below;
5. the Covered Person's Physician has recommended a drug, device, procedure, or other therapy that the Physician certifies, in writing, is likely to be more beneficial to the Covered Person, in the Physician's opinion, than standard therapies, or the Covered Person has requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition;
6. the Covered Person has been denied coverage by the Plan for a drug, device, procedure, or other therapy, recommended or requested pursuant to provision 5. above and has exhausted the Plan's Appeal Procedures; and
7. the drug, device, procedure, or other therapy, for which coverage has been denied, would be covered under the Plan except for the Plan's determination that the drug, device, procedure, or other therapy is Experimental/Investigational.

In the event that a Covered Person's Physician determines that a therapy would be significantly less effective if not promptly initiated, an expedited external review for terminal Illness may be requested. A request for an expedited external review for terminal Illness may be made orally or by electronic means provided that written confirmation of the request is submitted to the Plan not later than five (5) days after the request is made. The Covered Person's provider must certify that the requested or recommended therapy would be less effective if not promptly initiated.

The opinion of the majority of the experts on the panel selected by the independent review board will be binding on the Plan with respect to the Covered Person. If the opinions of the experts on the panel are evenly divided as to whether the therapy should be covered, the Plan will provide such coverage. The cost of the external review for terminal Illness shall be paid by the Plan.

If the Plan's initial denial of coverage for a therapy recommended or requested pursuant to provision 4. above is based upon an external review for terminal Illness of that therapy that meets the requirements of the applicable Ohio law for external reviews of a therapy for a terminal condition, a second external review of the therapy will not be required.

How to Request an Expedited Review of Medical Necessity

Written requests for an expedited review of medical necessity and written confirmation of oral or electronic requests for an expedited review of medical necessity should be addressed as follows and sent to:

EXPEDITED REVIEW OF MEDICAL NECESSITY
Jefferson County Government
c/o Medillume III, Inc.
1444 Hamilton Ave.
Cleveland, OH 44114

Oral requests for an expedited review of medical necessity should be made by calling:
(216) 575-5370 or (800) 919-3311.
Electronic requests for an expedited review of medical necessity should be addressed and sent as follows:
For fax transmissions:

EXPEDITED REVIEW OF MEDICAL NECESSITY
Jefferson County Government
c/o Medillume III, Inc.
Via Fax Transmission
and fax to (216) 566-0171

How to Request an Expedited Review for Terminal Illness

Written requests for an expedited review for terminal Illness and written confirmation of oral or electronic requests for an expedited review for terminal Illness should be addressed as follows and sent to:

EXPEDITED REVIEW FOR TERMINAL ILLNESS
Jefferson County Government
c/o Medillume III, Inc.
1444 Hamilton Ave.
Cleveland, OH 44114

Oral requests for an expedited review for terminal Illness should be made by calling:
(216) 377-7233.
Electronic requests for an expedited review for terminal Illness should be addressed and sent as follows:
For fax transmissions:

EXPEDITED REVIEW FOR TERMINAL ILLNESS
Jefferson County Government
c/o Medillume III, Inc.
Via Fax Transmission
and fax to (216) 566-0171

EXTERNAL AND INTERNAL APPEAL PROCESS

Request for external review. A claimant can file a request for an external review generally within four months after receiving a notice of an adverse benefit determination or a final internal adverse benefit determination.

Preliminary review. Within five business days after receiving the external review request, the Plan must complete a preliminary review of the request to determine whether the claimant was covered under the Plan at the time the health care expense was requested or, in the case of a retrospective review, was covered under the plan at the time the health care service was provided; the adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the eligibility requirements under the terms of the plan; the claimant has exhausted the plan's internal appeal process, if required to do so; and the claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan must issue a written notification to the claimant. If the request is complete but not eligible for external review, the notification must include the reasons for ineligibility and contact information for the DOL's Employee Benefits Security Administration. If the request is not complete, the written notification must describe the information needed to complete the request, and the claimant must be permitted to perfect the request within the four-month filing period or within 48 hours after receiving the notification, whichever is later.

Referral to independent review organization. The Plan must assign an independent review organization (IRO) that is accredited by the Utilization Review Accreditation Committee (URAC) or by a similar nationally recognized accrediting organization, to conduct the external review. The IRO will make a final decision within 45 days. The decision of the IRO is binding on the Plan. In order to prevent against bias and ensure independence, the plan must contract with at least three (3) IROs for assignments under the Plan and rotate claim assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection).

Reversal of plan's decision. Upon receipt of a notice of a final external review decision that reverses the adverse benefit determination or final internal adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review for Self-Insured Group Health Plans

Request for expedited review. The Plan must permit a claimant to make a request for an expedited external review if the claimant receives an adverse benefit determination (or a final internal adverse benefit determination) that involves a medical condition of the claimant for which the time frame for completion of an expedited internal appeal (or a standard external review in the case of a final internal adverse benefit determination) would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function. In addition, the Plan must permit a claimant to make a request for an expedited external review if the claimant receives a final internal adverse benefit determination that concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan must conduct a preliminary review and provide written notification, abiding by the same preliminary review and written notification requirements that apply to standard external reviews (as described above).

Referral to independent review organization. The Plan must assign the claim to an IRO, if it is determined that the request is eligible for external review, abiding by the same assignment requirements that apply to standard external reviews (as described above). The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process.

Notice of final external review decision. The plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the plan.

PROHIBITION OF RESCISSION OF COVERAGE

This Plan shall not rescind coverage for individuals who are covered under the plan, except in cases where the individual has engaged in fraud or made an intentional misrepresentation of material fact, as prohibited by the terms of the Plan and with advance notice. The term Rescission shall mean a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuation of coverage is *not* a rescission if the cancellation or discontinuance of coverage has only a prospective effect; or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. The Plan must provide at least 30 days' advance written notice to each participant who would be affected before coverage may be rescinded.

HIPAA PRIVACY PROVISIONS

This provision is intended to bring the Plan into compliance with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and § 164.504(f) is referred to as "the "504" provisions") by establishing the extent to which the Plan Sponsor will receive, use and/or disclose Protected Health Information.

1. The Plan's Designation of Person/Entity to Act on its Behalf

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

2. Definitions

All terms defined in the HIPAA Privacy Rule, shall have the meaning set forth therein.

3. The Plan's disclosure of Protected Health Information to the Plan Sponsor - Required Certification of Compliance by Plan Sponsor

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose Protected Health Information to the Plan Sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor by a health insurance issuer or HMO with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

a. the plan documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the "504" provisions;
b. the plan documents have been amended to incorporate the Plan provisions set forth in this addendum; and
c. the Plan Sponsor agrees to comply with the Plan provisions as modified by this addendum.

4. Permitted disclosure of individuals' Protected Health Information to the Plan Sponsor

a. the Plan (and any business associate acting on behalf of the Plan), or any health insurance issuer or HMO servicing the Plan will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this addendum.
b. all disclosures of the Protected Health Information of the Plan's individuals by the Plan's business associate, health insurance issuer, or HMO to the Plan Sponsor will comply with the restrictions and requirements set forth in this addendum and in the "504" provisions.
c. the Plan (and any business associate acting on behalf of the Plan), may not, and may not permit a health insurance issuer or HMO, to disclose individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions *or* in connection with any other benefit or employee benefit plan of the Plan Sponsor.
d. the Plan Sponsor will not use or further disclose individuals' Protected Health Information other than as described in the plan documents and permitted by the "504" provisions.
e. the Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the Plan (or from the Plan's health insurance issuer or HMO), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.
f. the Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
g. the Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the plan documents (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

5. Disclosure of individuals' Protected Health Information - Disclosure by the Plan Sponsor

a. the Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. § 164.524.
b. the Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. §164.526.
c. the Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. §164.528.
d. the Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.
e. the Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the Plan (or a health insurance issuer or HMO with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

f. the Plan Sponsor will ensure that the required adequate separation, described in item 7 below, is established and maintained.

6. Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor

a. the Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan Sponsor without the need to amend the plan documents as provided for in the "504" provisions, if the Plan Sponsor requests the summary health information for the purpose of:
   (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
   (2) modifying, amending, or terminating the Plan.

b. the Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the plan documents as provided for in the "504" provisions.

7. Required separation between the Plan and the Plan Sponsor

a. in accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may be given access to individuals' Protected Health Information received from the Plan or from a health insurance issuer or HMO servicing the Plan:
   The Deputy Auditors designated by the Employer;
   The Commissioners designated by the Employer;
   Director of Data Processing;
   Computer Programmers designated by the Employer; and
   Assistant Clerk, Commissioners' Office

b. this list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who receive individuals' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan sponsor provides for the Plan. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this addendum.

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

HIPAA SECURITY STANDARDS

This provision is intended to bring the Plan into compliance with the requirements of 45 C.F.R § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. Parts 160, 162 and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing the Plan Sponsor's obligations with respect to the security of Electronic Protected Health Information.

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

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

HOW TO FILE A CLAIM

* For medical claims, simply present your Plan identification card to the provider of service, and ask your provider to send the bill to the address shown on the ID card. Provider bills must include the appropriate diagnosis and procedure code information. If you are submitting bills instead of your provider, make sure you provide the following written information: the Employer's name, the Eligible Employee's name, and the Eligible Employee's member ID number.
* For dental claims, a completed dental claim form or an itemized bill from the Dentist's office will be accepted. If using a dental claim form, please complete Parts I and IV of the form and have your Dentist complete Parts II, III and V, then mail the completed form to the address printed on the form.
* For vision claims, complete the Employee's Statement, have the provider complete the Statement of Physician or Optometrist, and return the form to the address printed on the form.
* Proof of claims must be submitted to Self-Funded Plans, Inc. within the time frame specified in the Proof of Claims provision outlined in this summary plan description.

HOW TO APPEAL A CLAIM

If your claim is denied in whole or in part, you will receive written notification delivered in the same fashion as reimbursement for a claim. A claim worksheet will be provided by the Plan Supervisor, showing the calculation of the total amount payable, charges not payable, and the reason. If additional information is needed for payment of a claim, the Plan Supervisor will request same.

If a claim is denied in part or in full, you may appeal the decision. You or your authorized representative may examine pertinent documents (except for information in the file which the Physician does not wish made known to the claimant), and you may send a written letter of appeal outlining your position. The written appeal must be filed with the Plan Supervisor within 180 days after denial is received; however, it is suggested that it be filed promptly whenever possible.
Upon receipt of the written appeal, the Plan Supervisor will furnish copies of all relevant documents to the Plan Administrator for review and final decision.
A decision will be made within sixty (60) days unless special circumstances require extension, in which case such decision will be rendered no later than 120 days. A letter will be sent to you which references the pertinent Plan provisions supporting the decision. Unless the "Independent Review Provisions" apply, this decision will be final.

GENERAL INFORMATION

1. **NAME OF PLAN:** The Jefferson County Employee Health Plan
2. **NAME & ADDRESS OF PLAN SPONSOR:**
   Jefferson County Government
   301 Market Street
   Steubenville, Ohio 43952

   Jefferson Health Plan
   JEFFERSON COUNTY BD. OF EDUCATION
   2023 SUNSET BOULEVARD
   STEUBENVILLE, OHIO 43952
3. **EFFECTIVE DATE OF PLAN:** This plan document reflects amended and restated benefits effective August, 2023. This plan document reflects amended and restated benefits effective February 1. 2024
4. **EMPLOYER IDENTIFICATION NUMBER:** 34-6001501
5. **PLAN NUMBER:** 501
6. **ACCOUNT NUMBER:** 506-793
7. **TYPE OF PLAN:** This is a welfare plan providing medical, dental and vision benefits.
8. **TYPE OF ADMINISTRATION:** This is a self-insured plan. Certain administrative services are provided by a contract administrator retained by the Employer. Self-Funded Plans, Inc., which is not an insurance company, is the contract administrator.
9. **NAME, BUSINESS ADDRESS & TELEPHONE NUMBER OF THE PLAN ADMINISTRATOR:**
   Jefferson County Government
   301 Market Street
   Steubenville, Ohio 43952
   (740) 283-8500
10. **NAME OF THE DESIGNATED AGENT FOR SERVICE OF LEGAL PROCESS & ADDRESS AT WHICH PROCESS MAY BE SERVED ON SUCH AGENT:**
    Same as above
11. **THE SOURCES OF CONTRIBUTION TO THE PLAN:**
    Benefits provided under the Plan shall be unfunded and shall be paid solely from the general assets of the Employer. No employees shall have any right, title, or interest whatsoever in or to any investment reserves, accounts, or funds that the Employer may purchase, establish, or accumulate to aid in providing benefits under this Plan. Nothing contained in this Plan, and no action taken under its provisions, shall create a trust or fiduciary relationship of any kind between the Employer and a Covered Person. A Covered Person shall not acquire an interest greater than that of an unsecured creditor.
    The Employer requires employees to contribute to the cost of coverage through enrollment in an IRS Section 125 cafeteria plan using salary reduction agreements.
12. **NON-GRANDFATHERED PLAN:** This Plan is a non-grandfathered health plan under the Patient Protection and Affordable Care Act (the Affordable Care Act).

Jefferson County "Premium Only Plan" Summary Plan Description

INTRODUCTION

Purpose of Plan. The purpose of this Plan is to provide employees of the Employer a choice between cash and benefits under the following plans that are maintained by the Employer: Medical Plan and Supplemental Products Plan.
Cafeteria Plan Status. This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125.

DEFINITIONS

Wherever used herein, the following terms have the following meanings unless a different meaning is required by the context:
ACA means the Patient Protection and Affordable Care Act.
Code means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.
Effective Date means the original effective date of May 1, 2002. This Plan has been restated effective June 1, 2013.
Eligible Employees means the following: employees who were employed prior to February 1, 2002 and who are regularly scheduled to work at least 24 hours per week are eligible to be covered by the Plan. Employees who were employed on or after February 1, 2002 and who are in active pay status at least 30 hours per week on a regularly scheduled basis are eligible to be covered by the Plan.
Employer means Jefferson County, an entity organized under the laws of the state of Ohio.
Key Employee means any person who is a key employee as defined in section 416(i)(1) of the Code, with respect to the Employer.
Medical Plan means The Jefferson County Employee Health Plan, which includes medical, prescription drug, vision and dental benefits, as amended from time to time.
Participant means each Eligible Employee who participates in the Plan.
Plan means The Jefferson County Cafeteria Plan as set forth herein.
Plan Administrator means Jefferson County, or such other person or committee as may be appointed from time to time by the Employer to supervise the administration of the Plan. The Plan Administrator shall be responsible for complying with all the reporting and disclosure requirements of the Internal Revenue Service.
Plan Year means the period beginning on February 1st and ending on January 31st of each year.
Supplemental Products Plan means any plan sponsored by the Employer where employees can elect various voluntary supplemental benefits, at their own expense. This plan may be offered by different insurance carriers.

PARTICIPATION

Commencement of Participation. New Eligible Employees will be eligible to participate in the Plan on the first day of the month coinciding with or next following a continuous period of 60 days commencing on the first day a person is an Eligible Employee, provided they have complied with the election procedures set forth herein.
Cessation of Participation. A Participant will cease to be a Participant as of the earlier of:
1. the date on which the Plan terminates;
2. the end of the Plan Year, if the Participant chooses to terminate his participation under this Plan;
3. the date on which he ceases to be an Eligible Employee; or
4. the date on which he fails to pay any share of the cost of the Participant's coverage or any required premium (including payment by salary reduction).

OPTIONAL BENEFITS

Benefit Options. Each Participant may choose under this Plan to receive his full compensation for any Plan Year in cash or to have a portion of it applied by the Employer toward the cost of coverage available to the Participant under one or more of the following optional benefits: Medical Plan and Supplemental Products Plan.
Description of Benefits Other than Cash. While the election of one or more of the optional benefits may be made under this Plan, the benefits will be provided not by this Plan but by the plans described herein. The types and amounts of benefits available under each option described herein, the requirements for participating in such options, and the other terms and conditions of coverage and benefits under such option are as set forth in those plans.
Election of Optional Benefits in Lieu of Cash. A Participant may elect under this Plan to receive one or more of the optional benefits described herein, to the extent available to the Participant under the applicable plans, in accordance with the procedures described herein.
If a Participant elects coverage for any of the optional benefits offered, the Participant's regular cash compensation for the Plan Year will be reduced by the premium amount for the coverages elected.

Election Procedure. Each election form must be completed and returned to the Plan Administrator on or before such date as the Plan Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's compensation reduction agreement will apply. Each Participant who desires one or more of the optional benefits shall so specify on the appropriate election form and may elect to reduce his compensation resulting in pre-tax contributions, unless after-tax contributions are allowed and elected. An election will be deemed continuous and will automatically roll over from year to year unless the Eligible Employee terminates such election, which may be done prior to the beginning of the next Plan Year, or as described under the Change in Status provisions.

New Participants. Before, or as soon as practicable after, an Eligible Employee becomes a Participant under the Participation section of this Plan, the Plan Administrator shall provide an election form and salary reduction agreement to the Eligible Employee. If the Eligible Employee desires any optional benefit coverages for the balance of the Plan Year, he shall so specify on the election form and salary reduction agreement, and shall agree to a reduction in his compensation. The election form and salary reduction agreement must be completed and returned to the Plan Administrator on or before such date as the Plan Administrator shall specify, which date shall be before the beginning of the first pay period for which the Participant's salary reduction agreement will apply

Failure to Elect. A Participant's failure to return a completed election form to the Plan Administrator on or before the specified due date for the initial Plan Year of the Plan, or for the Plan Year in which he became a Participant, shall constitute an election to receive his full compensation in cash.

Irrevocability of Election by the Participant During the Plan Year. Any election made under the Plan (including an election made as a result of a Participant's failure to make an election), shall be irrevocable by the Participant during the Plan Year except as specified in the Change in Status provision.

Change in Status. The following are allowable Changes in Status that will permit a Participant to file a new election during the Plan Year (for the medical plan only).

1. A Participant may revoke an election in writing for the balance of the Plan Year and file a new election in writing if: (a) a change in status occurs; and (b) the election change satisfies the Consistency Rule of this Plan. An election satisfies the Consistency Rule of this Plan only if the election change is on account of and corresponds with a change in status that affects eligibility under an employer's plan. For the purpose of this paragraph, events which may result in a change in status include: (a) events that change a Participant's legal marital status; (b) events that change an employee's number of dependents (as defined in Section 152 of the Internal Revenue Code); (c) any of the following events that change the employment status of the Participant, the Participant's spouse or the Participant's dependents: termination or commencement of employment, a strike or lockout, the commencement of or return from an unpaid leave of absence; and a change in worksite; (d) events that cause a Participant's dependent to satisfy or cease to satisfy eligibility requirements for coverage; (e) a change in the place of residence of the Participant, the Participant's spouse or the Participant's dependent; and (f) such other events that the Plan Administrator determines will permit the revocation of an election (and, if applicable, the filing of a new election) during a Plan Year under regulations and rulings of the Internal Revenue Service. A new election to receive benefits under the Medical Plan or Supplemental Products Plan is subject to the provisions of the terms of the respective plan. In the event such plan does not permit enrollment at the time of the new election, the new election is not considered to satisfy the Consistency Rule of this Plan and the election cannot take effect under this Plan.
2. A participant may revoke an election for the Medical Plan in writing, for the balance of the Plan Year and file a new election in writing if the new election corresponds with the Special Enrollee rights contained in the Medical Plan.
3. In the event that a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody requires coverage for a Participant's child under, and such coverage is permitted under the terms of the Medical Plan, the Plan may change the Participant's election to reflect coverage for the child if the order requires coverage for the child under the Participant's plan; or permit the Participant to make an election change to cancel coverage for the child if the order requires the Participant's spouse, Participant's former spouse, or other individual to provide coverage for the child.
4. if a Participant, Participant's spouse, or Participant's dependent (who is covered by the Medical Plan), becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Plan may permit the Participant to make an election to cancel coverage of that Participant, Participant's spouse or Participant's dependent under the Medical Plan. If a Participant, Participant's spouse, or Participant's dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Plan may permit the Participant to make an election to reflect the commencement of coverage of that Participant, Participant's spouse or Participant's dependent provided that Participant, Participant's spouse or Participant's dependent is permitted to enroll for coverage at that time under the Medical Plan.
5. If during a period of coverage the coverage under one of the benefit options ceases or is significantly curtailed for all Participants generally, the Plan may permit affected Participants to revoke their elections under the Plan and make a new election on a prospective basis for coverage under another benefit option which provides similar coverage. If during a period of coverage a new benefit option is added, the Plan may permit affected Participants to elect the newly added option on a prospective basis and make corresponding election changes with respect to other benefit options which provide similar coverage. If during a period of coverage a benefit option is deleted, the Plan may permit affected Participants to elect another option on a prospective basis and make corresponding election changes

with respect to other benefit options in which provide similar coverage. The Plan may permit a Participant to make a prospective election change that is on account of and corresponds with a change made under the plan of the employer of the Participant's spouse, former spouse or dependent provided: (i) a cafeteria plan or qualified benefits plan of the employer of the spouse, former spouse or dependent permits participants to make an election change that would be permitted under regulations and rulings of the Internal Revenue Service; or (ii) the Plan permits Participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan or qualified benefits plan of the employer of the spouse, former spouse or dependent. Any revocation and new election under this section shall be effective at such time as the Plan Administrator shall prescribe, but not earlier than the first pay period beginning after the revocation and new election.

6. Depending on allowable cafeteria events, based on healthcare reform laws, an Eligible Employee who made a salary reduction election through his employer's cafeteria plan for health plan coverage with a fiscal year beginning in 2013 can prospectively revoke or change his election regarding the plan during that plan year. Also, an Eligible Employee who did not make a salary reduction election under his employer's cafeteria plan for health plan coverage with a fiscal deadline beginning in 2013 (before the applicable deadline under the cafeteria plan regulations) can make a prospective salary reduction for coverage on or after the first day of the cafeteria plan's 2013 plan year. All of this is subject to the election being allowable under IRS rules.
7. A participant may revoke an election for the Medical Plan in writing, for the balance of the Plan Year and file a new election in writing in order to purchase a Qualified Health Plan through a competitive marketplace established under section 1311 of the ACA, commonly referred to as an Exchange or Health Insurance Marketplace. The first situation involves a participating employee whose hours of service are reduced so that the employee is expected to average less than 30 hours of service per week but for whom the reduction does not affect the eligibility for coverage under the Medical Plan. The second situation involves an employee participating in an Employer's group health plan who would like to cease coverage under the group health plan and purchase coverage through a Marketplace without that resulting either in a period of duplicate coverage under the Medical Plan and the coverage purchased through a Marketplace or in a period of no coverage. Such revocation must meet the requirements of the Internal Revenue Code.

Changes by Plan Administrator. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Key Employees, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by highly compensated employees (as defined by the Code for purposes of the nondiscrimination requirement in question) or Key Employees with or without the consent of such employees.

Adjustment of Salary Reduction Agreement. If the cost of group health coverage available under one of the benefit options which is provided by an independent third-party provider increases or decreases during a Plan Year, a corresponding change shall be made in the salary reduction agreements of all Participants receiving such coverage in an amount to be determined by the Plan Administrator.

Automatic Termination of Election. Any election made under this Plan (including an election made through inaction) shall automatically terminate on the date the Participant ceases to be a Participant in the Plan, although coverage or benefits under the benefit options described herein may continue if and to the extent provided by such plan.

Cessation of Required Contributions. Nothing in this Plan shall prevent the cessation of coverage or benefits under the Medical Plan in accordance with the terms of each Plan, on account of a Participant's failure to pay the Participant's share of the cost of such coverage or benefits, through salary reduction or otherwise.

ADMINISTRATION OF PLAN

Plan Administrator. The administration of the Plan shall be under the supervision of the Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The Plan Administrator is provided with the sole discretionary power and authority to determine eligibility for benefits, and to interpret or construe the terms of the Plan and to determine questions of fact which arise in connection with the Plan. The Plan Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's powers will include, but will not be limited to, the following authority, in addition to all other powers provided by this Plan:

1. To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;
2. To interpret the Plan, in its sole discretion, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;
3. To decide all questions, in its sole discretion, concerning the Plan and the eligibility of any person to participate in the Plan;
4. To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and
5. To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing.

Reliance on Tables, Etc. In administering the Plan, the Plan Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of accountants, counsel or other experts employed or engaged by the Plan Administrator.
Indemnification of Plan Administrator. The Employer agrees to indemnify and to defend to the fullest extent permitted by law any employee or agent serving as the Plan Administrator or as a member of a committee designated as Plan Administrator (including any employee or former employee who formerly served as Plan Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

AMENDMENT AND TERMINATION OF PLAN

Amendment of Plan. The Employer reserves the right at any time or times to amend the provisions of the Plan to any extent and in any manner that it may deem advisable, by a written instrument signed by an authorized representative of the Employer.
Termination of Plan. The Employer will have no obligation whatsoever to maintain the Plan for any given length of time and reserves the right to discontinue or terminate the Plan at any time without liability, by a written instrument signed by an authorized representative of the Employer. Upon termination or discontinuance of the Plan, all elections and reductions in compensation relating to the Plan shall terminate.

MISCELLANEOUS PROVISIONS

Information to be Furnished. Participants shall provide the Employer and the Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.
Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, shall be construed as giving to any Participant or other person any legal or equitable right against the Employer or Plan Administrator, except as provided herein, and in no event shall the terms of employment or service of any Participant be modified or in any way be affected hereby. Further, none of the establishment of the Plan nor any amendment thereof, not the payment of any benefits, shall be construed as (a) creating any responsibility or liability of the Employer, or the administrator for the validity or effect of the program; (b) as a contract or agreement between any Employer and any Participant or other person; (c) as consideration for, or an inducement or condition of, employment of any Participant or other person, or as affecting or restricting in any manner or to any extent whatsoever the rights or obligations of any Employer or any Participant or other person to continue or terminate the employment relationship at any time; or (d) as to give any Participant or other person, the right to be retained in the service of any Employer or to interfere with the right of any Employer to discharge any Participant or other person at any time.
Governing Law. This Plan shall be construed, administered and enforced according to the laws of the State of Ohio.
Tax Treatment. Neither the Employer nor the Plan Administrator make any representation as to the tax treatment to be afforded any Participant with respect to his selection of a benefit in accordance with the terms of this Plan. Responsibility for the determination of the tax treatment of any benefit provided under the Plan shall be the sole responsibility of each Participant. In the event federal legislation is enacted limiting in any way the amount or selection of benefits, as the case may be, which may be provided under the Plan, the Employer reserves the right to unilaterally modify the amount or selection of benefits as the case may be.
Benefits Solely from General Assets. Except as may be required by law, the benefits provided under these Plans will be paid solely from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant; and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of the Employer from which any payment under the Plan may be made.
Misrepresentation. Any material misrepresentation on the part of a Participant making application for coverage or receipt of benefits shall render the coverage null and void.
Notice. Any notice given under the Plan shall be sufficient if given to the Plan Administrator, when addressed to its office; or if given to a Participant, when addressed to the Participant at his or her address that appears in the records of the Plan Administrator. It shall be the obligation of each Participant to maintain a current address with the Plan Administrator.
Family and Medical Leave Act of 1993. In the event of an approved leave under the Family and Medical Leave Act of 1993 and in accordance with the policies of the Plan Administrator, a Participant may revoke an existing election for the Medical Plan and make such other election for the remaining portion of the period of coverage as may be provided for under the Family and Medical Leave Act of 1993 and the policies of the Plan Administrator.
Reliance. The Plan Administrator shall not incur any liability in acting upon any notice, request, signed letter, telegram or other paper or document believed by the Plan Administrator to be genuine or to be executed or sent by an authorized person.
Entire Plan. The plan document and the documents incorporated by reference herein shall constitute the only legally governing documents for the Plan. All statements made by any Employer or Plan Administrator shall be deemed representations and not warranties. No oral statement or other communication shall avoid or reduce coverage under the

Plan, or amend or modify the terms of the Plan, or be used in defense to a claim, unless in writing signed by the Plan Administrator.