Plan Endorsement #11-SP

GROUP # P35983/049418

EFFECTIVE DATE January 1, 2025

ADMINISTRATOR ID# 27-2783518 PLAN # 501

NAME OF PLAN Wellness Insurance Network Employee Benefits Plan

PLAN DESCRIPTION Plan C

The following wording is hereby added to the Plan:

Wellness Insurance Network, of Chicago, IL hereby maintains a plan for payment of certain expenses for the benefit of its eligible employees known as the Wellness Insurance Network Employee Benefits Plan (Plan). The attached document serves as the summary plan description, plan description and plan document for the Plan.

Wellness Insurance Network assures its covered members that during the continuance of the Plan all benefits herein after described shall be paid to or on behalf of them in the event they become eligible for benefits.

The Plan is subject to all the terms, provisions, and conditions recited on the following pages hereof. The Plan is not in lieu of and does not affect any requirements for coverages by Workers' Compensation Insurance. This Plan is not subject to Employee Retirement Income Security Act of 1974 (ERISA). To the extent that a court of law determines otherwise, the Plan shall be deemed to be automatically amended to incorporate the applicate ERISA provisions where necessary.

Wellness Insurance Network has caused this Plan to take effect as of 12:01 A.M. Central Time on January 1, 2025 at Chicago, IL.

All other provisions of the Plan remain unchanged.

APPROVED AND ATTESTED:

BY DocuSigned by: Annie Miskewitch 8D21255BF5CE41E... TITLE WIN Board President

DATE 2/6/2025 | 17:32 EST

WELLNESS INSURANCE NETWORK

111 North Canal, Suite 550
Chicago, IL 60606
Phone: (312) 625-5616

Plan C Plan

This booklet describes the Medical, Dental and Vision benefits for Eligible Employees of Wellness Insurance Network.

Information Applicable to Plan 501

Administrator Identification Number
27-2783518

Effective
January 1, 2025

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KEY INFORMATION

PLAN ADMINISTRATOR/ PLAN SPONSOR CONTACT INFORMATION:
Wellness Insurance Network
C/O Marsh & McLennan Agency, LLC
111 N Canal, Suite 550
Chicago, IL 60606

SPONSOR IDENTIFICATION NUMBER (EIN) AS ASSIGNED BY THE INTERNAL REVENUE SERVICE (IRS):
27-2783518

PLAN NAME:
Wellness Insurance Network Employee Benefits Plan

PLAN CONTACT INFORMATION:
Administration through Marsh & McLennan Agency, LLC
Scott Remmenga
111 N Canal, Suite 550
Chicago, IL 60606
312-625-5616

PLAN NUMBER:
501

Privacy Officer
Lauren Rosenthal
Ela Area Public Library District

STOP LOSS COVERAGE:
The Administrator has purchased specific and aggregate stop-loss reinsurance coverage.

GROUP NUMBER:
P35999

SPD EFFECTIVE DATE:
January 1, 2025

PLAN YEAR:
The Plan Year ends each December 31st. The financial records of the Plan are kept on a Fiscal Year basis. The Fiscal Year ends each June 30th.

TYPE OF PLAN:
Welfare benefit plan

NAME AND ADDRESS OF THE CLAIMS PROCESSOR:

Medical and Dental Coverage
Blue Cross and Blue Shield of Illinois
1020 31st Street
Downers Grove, IL 60515

IMPORTANT NETWORK CONTACT INFORMATION:

Function	Network Name	Claims Filing Information	Phone Number	URL
Medical PPO Network	Blue Cross Blue Shield PPO	BCBS P.O. Box 805107 Chicago, IL 60680-4112	(800) 541-2767	www.bcbsil.com
Dental PPO	Blue Cross Blue Shield PPO	BCBS P.O. Box 805107 Chicago, IL 60680-4112	(800) 541-2767	www.bcbsil.com
Vision	EyeMed	EyeMed P.O. Box 8504 Cincinnati, OH 45040	(866) 939-3633	www.eyemedvisioncare.com

SUMMARY PLAN DESCRIPTION

Blue Cross Blue Shield of Illinois and EyeMed serve as the Plan's Claims Processors. Blue Cross Blue Shield of Illinois has developed a Medical Benefit Program booklet and EyeMed has developed a certificate of coverage (Benefit Booklets") to provide you an overview of your Medical, Dental and Vision Benefits provided under the Plan. The Benefit Booklets together with the this document serve as the Summary Plan Description (SPD) for the Plan and the Plan document. Please read the information in both portions of the SPD carefully so you will have a full understanding of your benefits. If you want more information or have any questions about your benefits under the Plan, please contact the Plan Administrator.

ELIGIBILITY AND ENROLLMENT

WHO IS ELIGIBLE:

- **Employees:** A regularly assigned, full-time Employee of Member Libraries with over 50 full time equivalent employees that works or is credited with 30 or more hours of service per week. Each Member Library shall determine its method for calculating hours of service, which method shall be communicated to Employees upon request, free of charge. Member Libraries with less than 50 full time equivalent employees varies from 30 hours – 40 hours per week. Your eligibility as a full-time Employee will be determined at hire date and no less frequently than annually and will generally be communicated to you during Open Enrollment.

  This definition specifically excludes independent contractors, temporary employees and part-time employees. However, the Plan may choose to extend coverage to any individual required to be offered coverage under the Affordable Care Act's Employer Shared Responsibility requirement, as long as such eligibility determinations are made in a nondiscriminatory manner.

  For the Dental Benefit only, a regularly assigned, part-time Employee of a Member Library that works 20 hours per week for at least one year may be eligible for the Dental Benefit. Your eligibility for the Dental Benefit as a part-time Employee will generally be communicated to you during Open Enrollment.

  If you enroll in the Medical Benefit, you will automatically be enrolled in the Vision Benefit as well.

- **Retirees:** All Qualified Retirees are eligible to participate in the Plan. A Qualified Retiree is an individual who (a) worked for a Member Library that participates in the Illinois Municipal Retirement Fund, and (b) at the time of retirement from the Member Library qualifies as a retiree under then-current Illinois Municipal Retirement Fund guidelines. If a member library is not part of IMRF and offers retiree coverage, requirements for retiree coverage will need to be provided to the plan administrator to be included in this document. Schaumburg Township District Library and Lincolnwood Public Library District currently do not offer retiree coverage.

- **Dependents**:
  - **Dependent Children:** Child(ren) up to age 26 (30 for military veteran dependents, see paragraph immediately below) consisting of natural children, stepchildren, foster children, adopted children, and children placed for adoption.

    Unmarried military veteran dependents are eligible under this Plan to their 30th birthday so long as they 1) reside in Illinois, 2) have served in the active or reserve components of the United States Armed Forces, including the National Guard, 3) have received a release or discharge other than a dishonorable discharge, and 4) have submitted a proof of service using a DD2-14 (Member 4 or 6) form, otherwise known as a "Certificate of Release or Discharge from Active Duty." This form is issued by the federal government to all veterans. For more information as to how to obtain a copy of the DD2-14, the veteran can call the Illinois Department of Veterans' Affairs at 1-800-437-9824 or the United States Department of Veterans' Affairs at 1-800-827-1000.

A child who is physically or mentally incapable of self-support upon attaining age 26 may be continued under the Plan, while remaining incapacitated and unmarried, subject to the covered Employee's own coverage continuing in effect. To continue a child under this provision, the Administrator must receive proof of incapacity within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

- **Spouse:** Spouse of the Employee who is a resident of the same country in which the Employee resides. To be an Employee's spouse, a person must have met all requirements of a valid marriage in the state of Illinois or of the state or jurisdiction in which the marriage was entered into. A marriage between persons of the same sex, a civil union, or a substantially similar legal relationship other than common law marriage, legally entered into in another jurisdiction, shall also be recognized in Illinois as a civil union. An individual meeting the criteria identified for a "domestic partner" shall also qualify as a spouse.

- **Domestic Partners:** In order to qualify as a domestic partner of an Employee of this Plan and to be considered as an eligible Dependent of the Plan, the document entitled "Declaration of Domestic Partnership" must be completed by both the Employee and domestic partner. If requested, the evidence of joint responsibility referenced in this document must be provided according to the provisions stipulated.

  Further, the Employee and partner qualifying for domestic partnership coverage under this Plan must agree, upon termination of the Domestic Partnership, to complete the "Termination of Domestic Partnership" and provide the document to the Plan Administrator within 31 days of such termination.

ELIGIBLE TO ENROLL

All Employees shall be eligible on first day of the month following 30 days of employment.

Each Dependent of the Eligible Employee becomes eligible for Dependent coverage under the Plan on the later of the following:

1. The date the Employee is eligible; or
2. The date the individual becomes a Dependent of the Employee if on that date the Employee is covered.

EFFECTIVE DATE

All persons become covered, as they become eligible subject to the following:

1. All Employees shall be eligible on first day of the month following the date of employment.
2. Each Dependent of the Eligible Employee becomes eligible for Dependent coverage under the Plan on the later of the following:
   - The date the Employee is eligible; or
   - The date the individual becomes a Dependent of the Employee if on that date the Employee is covered.

   Coverage for a spouse will begin from the date of marriage. Coverage for a newborn birth child will begin from the date of birth. Coverage for a child placed under legal guardianship, an adopted child or a child placed for adoption with the Employee will begin from the date of Placement for

Adoption. Coverage for a stepchild or foster child will begin from the date the child meets the definition of "Dependent."

With respect to a spouse, the spouse must be formally enrolled and appropriate coverage arranged within 31 days from date of marriage. With respect to a newborn birth child, the child must be formally enrolled and appropriate coverage arranged within 31 days from birth. With respect to a child placed under legal guardianship, an adopted child or child placed for adoption, the child must be formally enrolled and appropriate coverage arranged within 31 days from the date of Placement For Adoption. With respect to a stepchild or a foster child, the child must be formally enrolled and appropriate coverage arranged within 31 days from the date that the child meets the definition of "Dependent."

ENROLLMENT

- **Open Enrollment Period:**
  Each year, a period of time may be designated as an Open Enrollment period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that a Dependent who did not enroll during their initial eligibility period may enroll in a Plan. Coverage will become effective on the date specified by the Member Library.

- **Late Enrollment Period*:***
  In the event that the Plan Administrator fails to offer an otherwise eligible individual coverage due to an administration error, an individual may apply for coverage or add dependents. Please contact the Plan Administrator for more information.

- **Special Enrollment**
  The Plan permits a Special Enrollment period for an Employee (or a Dependent), who is eligible for coverage, but not enrolled, to enroll if the Employee (or Dependent) had other coverage and loses it, or if a person becomes a Dependent of the Employee through marriage, birth, adoption or Placement for Adoption. A person who enrolls during a Special Enrollment period is not treated as a late enrollee.

  An individual may be eligible for Special Enrollment if the Employee, at the time coverage is declined, provides a statement, in writing, indicating the reason for declining coverage. To be eligible for Special Enrollment, the Employee must have declined coverage due to coverage under another plan. However, Special Enrollment will be available to Employees that decline coverage without having coverage under another plan and subsequently enroll in other coverage and lose that coverage. The Employee must have had an opportunity for Late Enrollment, Open Enrollment or Special Enrollment under this Plan but again chose not to enroll. Special Enrollment is also available to an Employee or Dependent who becomes eligible for a premium assistance subsidy under Medicaid or a state Children's Health Insurance (CHIP) program with respect to this Plan.

  If the Employee declined coverage because the other coverage was COBRA coverage, then the COBRA coverage must be exhausted before Special Enrollment will be available. If the other coverage is not COBRA coverage, then to be eligible for Special Enrollment, the other coverage must be lost due to a loss of eligibility, or employer contributions must have ended. Loss of eligibility includes a loss of coverage due to:

  - divorce;

- legal separation;
- death;
- termination of employment, or reduction in hours of employment;
- relocating outside of an HMO's service area (only if there is no access to other coverage through the HMO);
- a plan no longer offering benefits to a class of similarly situated individuals even if the plan continues to provide coverage to other individuals;
- the Employee or Dependent is covered under a Medicaid plan or under a state CHIP program, and coverage of the employee or dependent under such a plan/program is terminated as a result of loss of eligibility for such coverage.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if their Dependent has a Special Enrollment right because the Dependent lost other health coverage.

Under Special Enrollment, the Employee must request enrollment, in writing within 31 days after the exhaustion of COBRA, or termination of the other coverage (other than Medicaid or Children's Health Insurance, see below), or the date of the marriage, birth, adoption or placement for adoption. If eligible, enrollment in the Plan, in cases of marriage, birth or adoption/Placement for Adoption, will be effective as of the date of the event; otherwise, coverage will be available no later than the first day of the first month beginning after the completed request for enrollment is received.

Under Special Enrollment, the Employee must request enrollment, in writing within 60 days after the termination of Medicaid or Children's Health Insurance (CHIP) coverage, or when eligible for a premium assistance subsidy under Medicaid or a state CHIP program. If eligible, enrollment in the Plan will be effective no later than the first day of the first month beginning after the completed request for enrollment is received.

TERMINATION OF COVERAGE:

- **Employee:** The coverage of any Employee covered under this Plan shall terminate on the earliest of the following :
  - The last day of the calendar month in which the Employee ceases to be eligible for coverage under the Plan; or
  - The date of termination of the Plan.

- **Dependent:** The coverage of any Dependent covered under this Plan shall terminate on the earliest of the following:
  - The last day of the calendar month in which such individual ceases to be an eligible Dependent under the Plan; or
  - The date the Employee's coverage terminates under the Plan.

MEDICAL BENEFIT - SCHEDULE OF COVERED EXPENSES AND PROVISIONS

I. MEDICAL CARE BENEFITS:

COVERED EXPENSES and PROVISIONS	In-Network	Out-of-Network
Calendar Year Deductible *(taken before benefits are payable unless waived)*	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family
Deductible Carry-Over	Any Covered Expenses incurred during October, November and/or December which are applied to the Covered Person's Deductible will also "carry-over" to the following year's Deductible.	
Out-of-Pocket Maximum per Calendar Year. *(Includes Calendar Year Deductible) After amount is reached, 100% level of benefits applies for that Calendar Year.* The following expenses do not apply to and are not affected by the Out-of-Pocket Maximum: • "Non-compliance penalty" (for failure to abide by pre-certification requirements). • Any out-of-pocket expenses that are for non-covered services or for services that are in excess of any Plan maximum or limit.	$3,500 per person $7,00 per family	$14,000 per person $28,000 per family
Precertification Penalty for Non-Compliance: Certain benefits are subject to a $300 penalty per occurrence ***(in addition to Deductible)*** for failure to follow the Pre-Certification Program provisions. Please refer to Pre-Certification Program section for additional information.	BCBS 1-800-635-1928	
Claims Filing Limit	All charges, and corresponding requested documentation, must be submitted within 1 year of the date incurred.	
Coordination of Benefits	If it is determined that this Plan is the Secondary Payer, Benefits will be adjusted and reduced (standard). Benefits payable from both plans shall not exceed 100% of the eligible U&C charges.	
Deductible and In-Network and Out-of-Network Out of Pocket Maximums are "aggregated," such that covered expenses applied to one also apply to the other.		

II. PRESCRIPTION DRUG BENEFIT:

COVERED EXPENSES and PROVISIONS	Deductible Applies Except Where Noted	
	In-Network	Out-of-Network
Your Prescription Drug Benefit is administered through BCBS. For prescription drug questions please call 1-800-423-1973 or visit www.bcbsil.com		
Prescription Drug Card Benefit *(up to 30-day supply per prescription through out-of-network pharmacies)*	*30-day supply:* 100% *90-day mail order supply:* 75%	*34-day supply:* 75%
Mail-Order Drug Benefit *(up to 91-day supply per prescription through mail order)*	100%	
Mail-Order Requirement	Optional.	
Specialty Drug Pharmacy Benefit *(includes certain injectable medications)* *Please refer to Prescription Drug Benefit section for further details.*	Covered	Not Covered
RX Out-of-Pocket Expense Limit:	See medical out-of-pocket maximum	
Note: Certain prescriptions considered to be "preventive" shall be covered at 100%, and no-copay will apply as per Federal Regulations		

III. PREVENTIVE CARE SERVICES:

COVERED EXPENSES and PROVISIONS		
	In-Network	**Out-of-Network**
Preventive Care Services - (*must be billed with a routine diagnosis).* This plan includes coverage for physical exams, immunizations, tests, labs, x-rays, pap smears and analysis, mammograms (age 40 and older, 1 per Covered Person per Calendar Year), PSA test, bone density tests (for women age 60 and older, every 5 Calendar Years) and every 5 Calendar Years, a choice between a sigmoidoscopy or a colonoscopy (age 50 and older). *This benefit also covers all services referenced within the Recommendations of the United States Preventive Service Task Force, Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention, and the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA*). This benefit specifically does not cover executive physicals, heart scans, full body scans, CAT scans, MRIs, PET or other similar tests.	100% Deductible waived.	80%, except for routine labs and x-rays *(See Outpatient Laboratory/ Radiology benefit section in this schedule).*
Comprehensive Ultrasound Screening of an Entire Breast or Breasts *If mammogram demonstrates heterogeneous or dense breast tissue, when Medically Necessary as determined by a Physician.*	100% Deductible waived.	80%, except for routine labs and x-rays *(See Outpatient Laboratory/ Radiology benefit section in this schedule).*
Smoking Cessation Drugs *Eligible expenses include Nicorette gum, epidermal patches, and acupuncture by a licensed practitioner and behavioral modifications by a licensed practitioner.*	100% Deductible waived (Must be authorized by a Physician – prescription items must be paid out-of-pocket and submitted for reimbursement)	

IV. PHYSICIAN SERVICES:

COVERED EXPENSES and PROVISIONS	Deductible Applies Except Where Noted	
	In-Network	Out-of-Network
Physician Office Visits - Exam charge only *Unless listed separately within this schedule.*	100%	80%
Urgent Care*	100%	80%
Second Surgical Opinion	100%	Paid same as In-network.
Emergency Room Physician Care*	Please refer to Emergency Room Services benefit in Section VI.	
Physical and, Occupational Therapy *Limited to a combined maximum of 60 Visits for office and Outpatient facility services, per Covered Person per Calendar Year.*	100%	80%
Speech Therapy	100%	80%
Diabetes Self-Management Education Program	100%	80%
All Care Rendered by a Chiropractor *All services provided by a chiropractor are limited to a combined maximum of 26 visits per Covered Person per Calendar Year, regardless of the place of service or services provided.*	100%	80%
Anesthesia and its Administration *(Inpatient/Outpatient)*	100%	80%
Allergy Injections, Serum, and Administration.	100%	100%
Other Physician Services *Does not include labs and X-rays; please see Section V for additional benefit coverage information*	100%	80%
If a referral is made to a non-network Physician or non-network specialist by a network Physician *(due to Medically Necessary services not being available In-Network).*	N/A	Paid same as In Network.
Non-Network Physician Services Received at a Network Hospital* *If services are performed by a 1) non-network anesthesiologist or 2) a non-network specialist, such as a radiologist or pathologist, limited to interpreting tests, who is requested or required by that network Hospital, the charges will be covered as if rendered by a network Physician.*	N/A	Paid same as In-Network.

*For coverages subject to the No Surprises Act, see IX, below.

V. OUTPATIENT/OFFICE (PHYSICIAN'S OFFICE AND FACILITY) LABORATORY/RADIOLOGY/PATHOLOGY SERVICES, INCLUDING ADMINISTRATION AND MRI, PET, AND CT SCANS:

COVERED EXPENSES and PROVISIONS	Deductible Applies Except Where Noted	
	In-Network	Out-of-Network
Routine Radiology and Pathology Administration and Interpretation Services * *Does not include MRI, PET or CT scans.*	100%	80%
Office/ Independent Lab/Outpatient Diagnostic and Radiology and Pathology Administration and Interpretation Services* *Does not include above services performed in conjunction with the following:* • *Chiropractic Care.* • *Emergency Room Services.* *Does not include MRI, PET or CT scans.*	100%	80%
Outpatient/Office/Independent Laboratory Imaging Services (MRI, PET, and CT scans)*	100%	80%

*For coverages subject to the No Surprises Act, see IX, below.

VI. FACILITY SERVICES:

COVERED EXPENSES and PROVISIONS	Deductible Applies Except Where Noted	
	In-Network	Out-of-Network
Emergency Room Services*	100%	
Inpatient Hospital Services* *Coverage is limited to:* • *Room and board not to exceed the semi-private room rate.* • *Necessary services and supplies including an intensive care unit and a cardiac care unit.* • *If admitted through the Hospital Emergency Room, this benefit will be covered at the In-Network level.* *Note: Room and board subject to the payment of semi-private room rate, unless the Hospital only has private rooms.* *Note: Payment of Out-of-Network Inpatient charges exceeding $50,000 will be limited to Medicare DRG Reimbursement Rate.*	100%	80%
Ambulatory Surgical Facility Charges for Outpatient Surgical Procedures*	100%	*Note: Coverage of Charges exceeding $15,000 will be limited to the Medicare ASC Reimbursement Rate, subject to the applicable 50% and deductible.*
Outpatient Hospital Facility Charges* *Note: Payment of Out-of-Network Outpatient charges exceeding $50,000 will be limited to Medicare APC Reimbursement Rate.*	100%	80%
Renal Dialysis *Note: For Out-of-Network charges due to renal dialysis, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses.*	100%	80%
Urgent Care Services Performed at a Hospital or Facility *(includes Physician charges)**	Please refer to Urgent Care benefit in Section IV.	

*For coverages subject to the No Surprises Act, see IX, below.

VII. MENTAL HEALTH AND SUBSTANCE USE SERVICES:

COVERED EXPENSES and PROVISIONS	Deductible Applies Except Where Noted	
	In-Network	Out-of-Network
BEHAVIOR HEALTH BENEFIT (Mental/Nervous/Substance Use Disorders)		
Treatment for Mental/Nervous and Substance Use Disorders.*	Paid same as any other service according to type of service, provider and place of service.	

*For coverages subject to the No Surprises Act, see IX, below.

VIII. OTHER COVERED SERVICES:

COVERED EXPENSES and PROVISIONS **Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered Expenses and Provisions.**	Deductible Applies Except Where Noted **In-Network**	 **Out-of-Network**
Other Covered Services/Items	100% Unless included in a separate category.	80% Unless included in a separate category.
Acupuncture	100%	80%
Artificial Limbs, Eyes and Larynx	100%	80%
Assisted Reproduction.	Not Covered.	
Autism Spectrum Disorders. Such diagnosis entails 1 or more tests, evaluations, or assessments to diagnose whether an individual has an autism spectrum disorder. Such tests, evaluations, or assessments must be prescribed, performed, or ordered by a physician licensed to practice medicine in all its branches, or a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders. For those diagnosed with this disorder, the following treatments are covered: 1. Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist; 2. Psychological care, meaning direct or consultative services provided by a licensed psychologist; 3. ***For Dependent Children only***: Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. Applied behavior analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior; and 4. ***For Dependent Children only***: Therapeutic care, including behavioral, speech, occupational and physical therapies addressing the following areas: a. Self-care and feeding b. Pragmatic, receptive and expressive language c. Cognitive functioning d. Applied behavioral analysis, intervention, and modification e. Motor planning f. Sensory processing All covered services must be prescribed by a physician. However, some of the services may be delivered by certified or licensed professionals who are not physicians (including but not limited to speech therapists, physical therapists, and occupational therapists). Autism spectrum disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified. Diagnosis of autism spectrum disorders means 1 or more tests, evaluations, or assessments to diagnose whether an individual has autism spectrum disorder that is prescribed, performed, or ordered by (a) a physician licensed to practice medicine in all its branches or (b) a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders.	100% Except as may be covered differently for specific services listed elsewhere in the schedule.	80% Except as may be covered differently for specific services listed elsewhere in the schedule.
Birthing Center	100%	100%
Casts, Splints, Trusses, Crutches and Braces	100%	80%
Chemotherapy	100%	80%
Contact Lenses or Glasses Following Cataract Surgery *Limited to first pair of either contact lenses or glasses following cataract surgery for initial replacement of natural lenses.*	100%	80%
Covered Medically Necessary Prescription Drugs *if not available through the Prescription Drug Benefit*	100%	80%

VIII. OTHER COVERED SERVICES:

COVERED EXPENSES and PROVISIONS **Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered Expenses and Provisions.**	Deductible Applies Except Where Noted **In-Network**	 **Out-of-Network**
Dental Treatment *when rendered by a Physician, dentist or oral surgeon for* ***a*** **fractured jaw** *or for* **accidental Injuries to natural teeth within 12 months** *after the accident (replacement or repair of a denture not covered)*; *removal of* **total bony impacted teeth**; *charges for* **medical care, services** *and* **supplies** *furnished by a Hospital during Medically Necessary confinement in connection with* dental treatment.	100%	80%
Durable Medical Equipment *Includes:* • *Cost to purchase or rent up to purchase price.* • *Equipment for administration of oxygen.* • *Equipment repair or replacement.*	100%	80%
Family Planning - Permanent Procedures *Includes:* • *Voluntary sterilization.* o *Female tubal ligation.* o *Male vasectomy.* • *Voluntary abortion.*	100%	80%
Family Planning – Temporary Procedures	Not Covered.	
Foot Orthotics *Limited to 1 set of inserts every 24 month period as prescribed by a Physician or specialist.*	100%	80%
Home Health Care *Limited to a maximum of 60 home care visits (one per day) per Covered Person per Calendar Year.* *Each 4 hours of service by a home health aide in a 24 hour period will be considered 1 home health visit.* *One visit by any other provider of services will be counted as 1 visit.*	100%	80%
Hospice Care *Includes all necessary services for the patient if prescribed by a Physician, and the patient's life expectancy is 6 months or less.*	100%	80%
Infertility Diagnosis and Testing *Infertility means the inability to conceive a child, or the inability to sustain a successful pregnancy.*	Paid same as any other service according to type of service, provider and place of service.	
Mastectomy Related Treatment *Includes charges in accordance with the provisions detailed under the definition of "Reconstructive Breast Surgery."* *Includes up to 2 mastectomy bras per Covered Person per Calendar Year.*	100%	80%
Obesity Surgery or Treatment Limited to 1 surgical procedure per Covered Person per Lifetime. Benefit does not apply unless Covered Person: • Has attempted weight loss in the past without successful long-term weight reduction; and • Meets either a physician-supervised nutrition and exercise program or a multidisciplinary surgical preparatory regimen. Benefit does not apply unless the *Adult* Covered Person: • Has a body mass index (BMI) exceeding 40; *or* • Has a BMI greater than 35 in conjunction with any of the following severe co-morbidities: o Clinically significant obstructive sleep apnea (i.e., patient meets the criteria for treatment of obstructive sleep apnea); or o Coronary heart disease; *or* o Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management); *or* o Type 2 diabetes mellitus.	100%	80%

VIII. OTHER COVERED SERVICES:

COVERED EXPENSES and PROVISIONS **Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered Expenses and Provisions.**	Deductible Applies Except Where Noted **In-Network**	 **Out-of-Network**
Organ or Tissue Transplant Procedures **For cornea, skin, or cartilage transplants:** *The Covered Person, who is the transplant recipient, must receive 2 opinions with regard to the need for transplant surgery. The opinions must be in writing by board-certified specialists in the involved field of surgery. The specialists must certify that alternative procedures, services or courses of treatment would not be effective in the treatment of the condition.*	100%	80%
For all other Organ and Tissue Transplants: *For specific details on all elements of this coverage, Please refer to the Transplants section.*	Coverage and Benefit Level based upon place and type of service.	Not Covered.
Orthopedic Shoes *Limited to specially molded and Medically Necessary shoes.* *Limited to 1 pair per Covered Person per Calendar Year.*	100%	80%
Other Medical Equipment	100%	80%
Private Duty Nursing Services *Includes services of a registered professional nurse (R.N.) or a licensed practical nurse (L.P.N.), when Medically Necessary, other than one who ordinarily resides in your home, or who is a member of the immediate family.* *Does not include inpatient private duty nursing.* *Limited to a maximum of 100 visits (one per day) per Covered Person per Calendar Year.*	100%	80%
Professional Ambulance Service *Transportation from the city or town in which the Covered Person becomes disabled, to and from the nearest Hospital qualified to provide treatment for the accidental bodily Injury or disease.*	100%	100%
Prosthetic Medical Appliances *Limited to charges for the purchase, maintenance, or repair of internal and external permanent or temporary aids and supports for defective body parts.*	100%	80%
Routine Newborn Nursery Care *(including circumcision)*	100%	80%
Services/Items for Covered Persons Residing Outside the PPO Network Area	N/A	Paid same as any other In-Network service according to type of service, provider and place of service.
Skilled Nursing Facility *Includes Extended Care Facility.* *Limited to 120 days per Covered Person, per the same or related causes.* *Limited to the usual charge of the facility for semi-private care, including room and board and all other services.*	100%	80%
TMJ *(Temporomandibular Joint Dysfunction)* *Limited to the diagnosis and non-surgical treatment.* *Benefit does not include charges for orthodontic services.*	100%	80%
Wigs *for hair loss resulting from the treatment of cancer.*	100%	80%

Please Refer to the Pre-Certification Program, Prescription Drug Benefit, Transplants, and Exclusions sections for additional coverage details.

IX. SERVICES SUBJECT TO THE NO SURPRISES ACT:

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

"Recognized amount" means the amount which the copayment is based on for the below covered healthcare services when provided by out-of-network providers:

- Out-of-network Emergency healthcare services.
- Non-Emergency covered healthcare services received at certain in-network facilities by out-of-network physicians that have not satisfied the notice and consent criteria of the No Surprises Act. For the purpose of this provision, "certain in-network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act)*, a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act)*, an ambulatory surgical center described in *section 1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary of HHS.

The amount is based the lesser of the qualifying payment amount as determined under applicable law (the amount provided under state law or the median in-network contracted rate) or the amount billed by the provider or facility.

The recognized amount for air ambulance services provided by an out-of-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law (the amount provided under state law or the median in-network contracted rate) or the amount billed by the air ambulance service provider.

Note: Covered healthcare services that use the recognized amount to determine your cost sharing may be higher or lower than if cost sharing for these covered healthcare services were determined based upon an Medicare ASC Reimbursement Rate.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance), as a percentage (or copay) of the recognized amount. You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount, as a percentage (or copay) of the recognized amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Illinois state law (Illinois Public Act 096-1523) protects you from "balance" or "surprise" bills when you receive care at an in-network facility or ambulatory surgery center from out-of-network providers who provide radiology, anesthesiology, pathology, neonatology, or emergency physician services at that in-network facility.

In these situations, you cannot be charged greater out-of-pocket expenses than you would have been for covered, in-network physician or provider services. The out-of-network provider should not send you a bill.

Exceptions to Illinois Surprise Billing Protections

You could, however, still be required to pay an out-of-network bill in certain situations. These protections only apply to certain out-of-network providers who are based in an in-network facility; if the facility where you receive these services itself is out-of-network, you can also receive an out-of-network bill. Similarly, these protections do not apply if you purposely choose a provider not within your insurance network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on the recognized amount and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact 1-800-985-3059 or

The Illinois Department of Insurance
320 West Washington Street Springfield, IL 62767
1-877-527-9431.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

PRE-CERTIFICATION PROGRAM

Your Plan also includes a **Pre-Certification Program**. The toll-free number You must use for pre-certification is shown on Your member ID card. **Failure to follow the guidelines listed below will subject Your benefits to a Penalty for Non-Compliance as discussed in this section and referenced in the Schedule of Covered Expenses and Provisions.**

Pre-Certification is required for the following services:

1. All home health care services, including home uterine monitoring.
2. Artificial intervertebral disc surgery.
3. Dental implants and oral appliances.
4. Elective (non-emergent) transportation by ambulance or medical van, and all transfers via air ambulance.
5. Inpatient Confinements:
    a. Surgical and non-surgical, excluding vaginal or Caesarean deliveries.

b. Skilled nursing facility.
c. Rehabilitation facility.
d. Inpatient hospice (except Medicare).
e. Observation stays greater than 23 hours.

6. Lumbar spinal fusion surgery.
7. Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint.
8. Reconstructive procedures that may be considered cosmetic:
   a. Blepharoplasty/canthopexy/canthoplasty.
   b. Excision of excessive skin due to weight loss.
   c. Rhinoplasty/rhytidectomy.
   d. Gastroplasty/gastric bypass.
   e. Pectus excavatum repair.
   f. Breast reconstruction/breast enlargement.
   g. Breast reduction/mammoplasty.
   h. Surgical treatment of gynecomastia.
   i. Lipectomy or excess fat removal.
   j. Sclerotherapy or surgery for varicose veins.
9. Selected durable medical equipment:
   a. Electric or motorized wheelchairs and scooters.
   b. Clinitron and electric beds.
   c. Limb prosthetics.
   d. Customized braces.
10. The following conditionally eligible services:
   a. Stereotactic radiosurgery.
   b. Somatosensory evoked potential studies.
   c. Cognitive skills development.
   d. Hyperbaric oxygen therapy.
   e. Osteochondral allograft/knee.
   f. Cochlear device and/or implantation.
   g. Osseointegrated implant.
   h. Percutaneous implant of neuroelectrode array, epidural.
   i. GI tract imaging through capsule endoscopy.
   j. Botox injections -- botulinum toxin type A.
   k. Alpha 1-proteinase inhibitor – human.
   l. Negative pressure wound therapy pump.
   m. High-frequency chest wall oscillation generator system.
11. Uvulopalatopharyngoplasty, including laser-assisted procedures.

If Your Physician recommends an Inpatient confinement or any of the services listed above, please follow these steps:

1. Notify Your Physician that You participate in a Pre-Certification Program. Please note that this applies even if this Plan is the secondary payer under Coordination of Benefits.

2. You or Your Physician must call the number shown on Your member ID card 2 weeks before or, if less

than 2 weeks, as soon as scheduled for an elective Hospital admission. Note: For exceptions, please refer to the section of this document entitled "Compliance Regulations," and see the subheading "Statement of Rights Under the Newborns' and Mothers' Health Protection Act".

3. If You have an emergency admission, pre-certification is required within 48 hours or the next business day following admission.

   The following information will be needed to pre-certify:

Regarding Patient:	**Regarding Employee:**
Name	Name
Address	Address
Telephone #	Telephone #
Date of Birth	Date of Birth
Relationship to Employee	Gender
Physician's Name	Social Security Number
Physician's Phone Number	Name of Employer
Hospital/Address	Name of Claims Processor:

4. A nurse may call Your Physician to review a proposed Inpatient admission or other listed service. If admission is necessary, an assigned length of stay will be determined. If additional days are later thought to be necessary, these additional days must also be pre-certified.

5. When You or Your Physician call to pre-certify an Inpatient admission or other listed service, the call will be logged so that:

   a. The facility can verify that pre-certification has been done and can track expected length of stay.

   b. The Claims Processor can verify that the pre-certification requirements have been met when the claim is received for processing.

Note: Pre-Certification assists in determining medical necessity and the best place for treatment. This service, however, does not guarantee payment, which is subject to eligibility and coverage at the time services are rendered.

PENALTY FOR NON-COMPLIANCE:

Unless prohibited under federal law, the non-compliance penalty specified in the Schedule of Covered Expenses and Provisions will apply under one or more of the following circumstances: a) a pre-certification call is not made according to the instructions within this section; b) an Inpatient stay exceeds the amount of days pre-certified; or c) a patient is admitted as an Inpatient when treatment could have been performed on an Outpatient basis.

This penalty will be applied in addition to any applicable Deductible and will not be applied to any Out-of-Pocket Maximum as specified in the "Schedule of Covered Expenses and Provisions". The penalty will be applied to covered expenses that were incurred during the days that were not pre-certified.

PRESCRIPTION DRUG BENEFIT

Prescription drug benefits are provided through the pharmacy benefit plan manager listed in the Prescription Drug Benefit section of the Schedule of Covered Expenses and Provisions. Benefits will be paid as stated in the Schedule of Covered Expenses and Provisions for charges made by a participating pharmacy for treatment of a Covered Person's Illness or Injury. A covered charge is considered made on the date the prescription is dispensed by the pharmacist.

GENERAL PHARMACY BENEFIT

Prescriptions Covered:

1. Acne medications.
2. ADD and narcolepsy drugs.
3. Diabetic medications and supplies including:
   a. Antihyperglycemics, injectable (e.g., Byetta & Symlin).
   b. Blood glucose testing devices (e.g., lancing devices).
   c. Diabetic testing agents for glucose testing of blood/urine.
   d. Glucose elevating agents (e.g., Glucagon).
   e. Insulin (includes pre-filled syringes).
   f. Insulin delivery devices (e.g., pens).
   g. Insulin needles and syringes.
   h. Lancets.
4. Emergency allergic reaction kits (e.g., Epipen, Epipen Jr.).
5. Legend prescription drugs are covered unless specified otherwise in this Prescription Drug Benefit section (includes Schedule II, III, IV, and V Controlled Substances).
6. Lovenox - injectable.
7. Other drugs which under applicable state laws may only be dispensed with a prescription.
8. Prenatal vitamins that require a prescription.
9. Preventive care (covered at 100%) as required by federal law.
10. Smoking cessation drugs – Limited to a 180 day supply per Covered Person per Calendar Year with generic nicotine replacement products (nicotine patch, gum and lozenges) and/or a 180 day supply per Covered Person per Calendar Year with generic Zyban or Chantix. Over-the-counter (OTC) products require a prescription for coverage to apply.

Enhanced Prescriptions Coverage:

A. This Prescription Item A does not apply and is intentionally left blank.

B. Contraceptives including:

1. This Prescription Item 1 does not apply and is intentionally left blank.
2. Emergency (e.g., Plan B).
3. Extended cycle oral Mail Order Only.
4. Oral/transdermal/intravaginal ring (e.g., Ortho-Evra, Nuvaring).

C. This Prescription Item C does not apply and is intentionally left blank.

D. This Prescription Item D does not apply and is intentionally left blank.

Prescriptions Not Covered Under Prescription Drug Benefit:

1. *Anorexients.*
2. *Anti—obesity.*
3. *Any OTC medication, unless specified otherwise.*
4. *Biological sera.*
5. *Blood products.*
6. *Blood serum.*
7. *Charges for the administration or injection of any drug.*
8. *Cosmetic Drugs including anti-wrinkle agents, hair growth stimulants, hair removal products.*
9. *Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual.*
10. *Experimental medications which do not have a National Drug Code Number (NDC).*
11. *Immunization agents that require a prescription and are not covered under preventive care.*
12. *Prescriptions which a Covered Person is entitled to receive without charge under Workers' Compensation laws.*
13. *Therapeutic devices or appliances including hypodermic needles, syringes, support garments, ostomy supplies, durable medical equipment, and non-medical substances regardless of intended use.*
14. *Growth hormone for short stature diagnosis.*
15. *Non-legend drugs other than those listed above.*
16. *Fluoride supplements (that require a prescription and are not covered under preventive care).*
17. *Contraceptives including:*
    1. *Diaphragms/Kits.*
    2. *Implants (e.g., Implanon).*
    3. *Injectable (e.g., Depo Provera).*
    4. *Intrauterine Devices (IUD).*
18. *Injectable medications that require a Prescription.*
19. *Impotency drugs.*

MAIL ORDER DRUG BENEFIT

This benefit offers a mail order service which delivers required prescription drugs directly to Your home after a per prescription co-pay has been made (see Schedule of Covered Expenses and Provisions for co-pay amount) from an In-Network drug provider. The mail order drug benefit permits up to a 90-day supply of medication and up to one year of refills upon authorization.

You should receive a packet providing complete details on how to use Your mail order drug benefit. If You have any questions regarding this aspect of Your coverage, please contact Your Plan Administrator.

SPECIALTY DRUG PHARMACY BENEFIT

Certain specialty medications may be required to be purchased through Your pharmacy vendor's or BCBS' specialty pharmacy program. Typically, these medications are very costly, require special storage or handling, are for long term use, or require careful monitoring and management. You will be notified by the pharmacy at the time of purchase if a particular drug is in this specialty pharmacy program, or You may call the pharmacy vendor (see Your member ID card) as soon as a drug has been prescribed to determine how it must be dispensed. The specialty pharmacy unit will coordinate fast shipment to the location a member chooses, such as Your home or Your Physician's office. Alternatively, if Your pharmacy vendor indicates that they cannot dispense the drug, please contact BCBS' customer service team (see Your member ID card) to determine how the specialty drug that has been prescribed must be dispensed. Please refer to previous pages for coverage provisions.

TRANSPLANTS

Institute of Excellence (IOE):

This is a facility that is contracted with Aetna to furnish particular services and supplies to You in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Transplant Expenses:

Once it has been determined that You or one of Your Dependents may require an organ transplant, You, or Your physician should call the pre-certification department to discuss coordination of Your transplant care. Aetna will coordinate all transplant services. In addition, You must follow any pre-certification requirements. Organ means solid organ; stem cell; bone marrow; and tissue.

While all organ/tissue transplants (other than cornea or skin transplants) are covered only under these provisions, benefits may vary if an Institute of Excellence (IOE) facility or non-IOE is used. The IOE facility must be specifically approved and designated by Aetna to perform the procedure You require. A transplant will be covered as network care only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants that is provided by a facility that is not specified as an IOE network facility, even if the facility is considered as a network facility for other types of services, will not be considered network care and will not be eligible for the optional travel & lodging expenses specified later in this section. Please read each section carefully.

Covered Transplant Expenses:

Covered transplant expenses include the following:

- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are Your: biological parent, sibling or child.
- Inpatient and outpatient expenses directly related to a transplant**.**
- Charges made by a Physician or transplant team.
- Charges made by a Hospital**,** outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date You are discharged from the Hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.
The four phases of one Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant Evaluation/Screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
2. Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.
3. Transplant Event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to You and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during Your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during Your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up Care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For the purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart.
- Lung.
- Heart/Lung.
- Simultaneous Pancreas Kidney (SPK).
- Pancreas.
- Kidney.
- Liver.
- Intestine.
- Bone marrow/stem cell transplant.
- Multiple organs replaced during one transplant surgery.
- Tandem transplants (stem cell).
- Sequential transplants.
- Re-transplant of same organ type within 180 days of the first transplant.
- Any other single organ transplant, unless otherwise excluded under the Plan.

The following will be considered to be more than one Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant).
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant).
- Re-transplant after 180 days of the first transplant.
- Pancreas transplant following a kidney transplant.
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

Limitations:

The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence.
- Services and supplies furnished to a donor when recipient is not a covered person.
- Home infusion therapy after the Transplant Occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness.
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.

Optional Travel & Lodging Expenses:

Distance Requirement:

The IOE facility must be more than 100 miles from the patient's residence.

Travel Allowances:

Travel is reimbursed between the patient's home and the facility for round trip (air, train or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll cost are reimbursed. Mileage Reimbursement is based on the current IRS published rate, as adjusted periodically for inflation.

Lodging Allowances:

Reimbursement of expenses incurred by patient and companion for hotel lodging away from home is reimbursed at a rate of $50 per night per person (or $100 per night total).

Overall Maximum:

Travel & lodging reimbursement is limited to $10,000 for any one transplant or procedure type, including tandem transplants. This is a combined maximum for the member, companion and donor.

Companions:

Adult – 1 companion is permitted.
Child – 1 parent or guardian is permitted

MEDICAL BENEFIT - EXCLUSIONS

No payment will be made under this Plan for expenses incurred by a Covered Person based on the below exclusions *(unless specifically stated within the Schedule of Covered Expenses and Provisions*):

1. for or in connection with an Injury or Illness for which the Employee or Dependent is entitled to benefits under any Workers' Compensation, Occupational Disease, or similar law;
2. for care and treatment of an Injury or Illness arising out of, or in the course of, any employment for wage or profit;
3. in a Hospital owned or operated by the United States Government or for services or supplies furnished by or for any other government unless payment is legally required;
4. for charges which the Covered Person is not legally required to pay or for charges which would not have been made if no coverage had existed;
5. which are not Reasonable and/or in excess of Usual and Customary Charges (depending on contract provisions, this limitation may not apply to charges from network providers or non-network providers who are utilized as a result of requests or requirements of network providers);
6. which are for care or treatment which is not Medically Necessary;
7. for custodial care (Expenses incurred to assist a person in daily living activities are considered costs for custodial care. Costs for medical maintenance services and supplies in connection with custodial care due to age, mental or physical conditions, are not covered if such care cannot reasonably be expected to improve a medical condition.);
8. due to accidental bodily Injury or Illness resulting from participation in an insurrection or riot, or participation in the commission of an assault or felony;
9. for purchase or rental of personal comfort items or supplies of common use; for purchase or rental of blood pressure kits, exercise cycles, air purifiers, air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, escalators, elevators, saunas, steamrooms and/or swimming pools;
10. for non-medical expenses such as preparing medical reports, itemized bills or charges for mailing;
11. for training, educational instructions or materials, even if they are performed or prescribed by a Physician;
12. for legal fees and expenses incurred in obtaining medical treatment;
13. for genetic testing and counseling (except as may be specifically stated as covered elsewhere in this document);
14. for Friday and Saturday admissions unless due to a Medical Emergency or if surgery is scheduled within the 24 hour period immediately following admission;
15. for treatment by a Physician, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N) if the Physician or nurse is related by blood, marriage, or by legal adoption to either the Covered Person or a spouse, or ordinarily resides with the Covered Person;
16. for any expense in excess of any maximum or limit as stated elsewhere in this document;
17. for failure to provide any additional documentation or information as may be requested pursuant to the

"Procedures For Filing Claims" section of this Plan;

18. for charges for travel or accommodations, whether or not recommended by a Physician, unless specifically stated as covered;
19. for charges incurred before coverage was effective or after it was terminated;
20. for charges incurred as a result of radioactive contamination or the hazardous properties of nuclear material;
22. except as stated in the Schedule of Covered Expenses and Provisions, 1) for treatment of or to the teeth, the nerves or roots of the teeth, and 2) for the repair or replacement of a denture,
23. for research studies not reasonably necessary to the treatment of an Illness or Injury;
24. for occupational therapy when it is not a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function;
25. for speech therapy when it is rendered for other than the correction of a physical impairment caused by Illness, Injury or congenital deformity;
26. for vitamins (except prescription pre-natal and pediatric vitamins); for over-the-counter drugs regardless of being prescribed by a Physician, unless required by federal law;
27. for routine foot care such as removal of corns, calluses or toenails, except in the treatment of a peripheral-vascular disease when recommended by a medical doctor or doctor of osteopathy;
28. for splints or braces for non-medical purposes (i.e., supports worn primarily during participation in sports or similar physical activities;
29. for any form of medication or treatment not prescribed in relation to an Injury, Illness or pregnancy, unless stated as covered elsewhere in this document
30. for growth hormones for children with short stature (short stature based upon heredity and not caused by a diagnosed medical condition);
31. on account of any declared or undeclared act of war;
32. for charges in connection with Cosmetic Surgery/Treatment, except to correct deformities resulting from Injuries sustained in an accident; or due to an Illness such as breast cancer (including all services mandated by federal provisions related to mastectomy treatment – see definition of "Reconstructive Breast Surgery Coverage"); or to correct a functional disorder (functional disorders do not include mental or emotional distress related to a physical condition); or unless treatment is for correction of a functional abnormal congenital condition;
33. for any service rendered to a surrogate mother for the purposes of childbirth;
34. for expenses incurred for cryo-preservation and storage of sperm, eggs and embryos, except for those procedures which use a cryo-preserved substance;
35. for charges incurred outside the United States if travel to such a location was for the primary purpose of obtaining medical services, drugs or supplies;
36. for special education, counseling, or other services for diagnosis pertaining to developmental delay, learning deficiencies or behavioral problems, unless:

- the diagnosis is listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered, and
- the treatment provided and the provider of such treatment is not excluded under any other provisions of the Plan;

37. for experimental or investigational services as defined in the Aetna Clinical Bulletins; or, for treatment not deemed clinically acceptable by (1) the National Institute of Health; or (2) the FDA; or (3) the Centers for Medicare and Medicaid Services (CMS); or (4) the AMA; or a similar national medical organization of the United States;
38. for routine eye examinations, unless required by federal law; for eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses, except as stated in the Schedule of Covered Expenses and Provisions; for any procedure, treatment or exam in connection with refractive disorders; for eye surgery such as radial keratotomy;
39. for routine hearing examinations, unless required by federal law;
40. for hearing aids, or the fitting thereof;
41. for instruction or activities for weight reduction or weight control, including charges for vitamins, diet supplements, or physical fitness programs even if the services are performed or prescribed by a Physician;
42. for surgical reversal of elective sterilizations; for contraceptive devices (except as indicated under the "Prescription Drug Benefit");
43. for chelation (metallic ion) therapy, except as approved by the Food and Drug Administration;
44. for "nicotine patches" or other forms of anti-smoking medication or treatment (except as stated in the "Prescription Drug Benefit");
45. for care and treatment for hair loss including wigs, hair transplants, hair implants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy;
46. for services and supplies received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, trustee or similar person or group;
47. for Out-of-Network charges due to renal dialysis, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses;
48. except as required by the No Surprises Act, for Out-of-Network Hospital Inpatient or Outpatient charges exceeding $50,000, payment will be limited to the Medicare DRG or APC Reimbursement Rate. If a Medicare DRG or APC Reimbursement Rate is not available, then reimbursement will be limited to the Rate of the next closest Hospital; and
49. except as required by the No Surprises Act, for Out-of-Network Ambulatory Surgical Center charges exceeding $15,000, payment will be limited to the Medicare ASC reimbursement fee schedule.

DENTAL BENEFIT

Your Dental Plan contains a PPO (Preferred Provider Organization). The name of the organization is indicated on the front of Your ID card, along with instructions regarding where to file dental claims. There are specific providers associated with the PPO, and PPO dental providers have agreed to provide dental services or supplies at a negotiated charge which is likely to be less than that charged by non-PPO providers for the same service. Additionally, by using a PPO dental provider, you will be assured that you will not be responsible for paying any charges in excess of the Reasonable and Customary Charge. If you use a non-PPO dental provider and that provider charges in excess of the Reasonable and Customary amount, any such excess charges will be entirely your responsibility. Please refer to the "Schedule of Benefits" on the following page for coverage levels applied to different types of dental treatment for all dental providers, but bear in mind the advantages to using PPO dental providers described above. For assistance in locating a PPO provider near you, or to verify that a provider is in the PPO network, visit the website listed on Your ID card. As a final step in the process, call the "Provider Referral Number" listed on Your ID card.

A Covered Person has a free choice of any provider. At any time, the Covered Person may choose any qualified provider with the understanding that different benefits may apply according to the provisions of the Plan.

DENTAL BENEFIT- SCHEDULE OF COVERED EXPENSES AND PROVISIONS

I. DENTAL CARE BENEFITS

COVERED EXPENSES AND PROVISIONS	
	Coverage
Calendar Year Deductible	$50 per person $150 per family
Calendar Year Benefit Maximum	$1,500 per person* *Initial oral examination and routine oral examinations are not subject to the Benefit Maximum.
Calendar Year Orthodontic Benefit Maximum	$500 per person
Lifetime Orthodontic Benefit Maximum	$1,000 per person
Deductible Carry-Over	N/A.
Claims Filing Limit	All charges and corresponding requested documentation must be submitted within 1 year of the date incurred.
All benefits are limited to Usual and Customary Charges.	
ALTERNATE TREATMENT *If more than one method of treatment is possible, the Covered Dental Charges will be limited to the Usual and Customary charges appropriate for those services and supplies which are customarily employed nationwide in the treatment of such condition and which are recognized by the dental profession to be appropriate methods of treatment, taking into account the total oral condition of the family member.*	
TREATMENT PLAN *You may wish to have an estimate of benefits payable before beginning treatment for extensive dental work. To receive this estimate, please have Your Dentist submit a Treatment Plan to the BCBS of Illinois before beginning a course of treatment which can reasonably be expected to involve Covered Expenses of $500 or more.*	

II. PREVENTIVE CARE SERVICES

COVERED EXPENSES AND PROVISIONS	In-Network	Out-of-Network
Preventive Care Waiting Period	0 months	0 months
Initial oral examination	100% Deductible waived.	100% Deductible waived.
Routine oral examinations *Limited to 2 exams per benefit period per Covered Person.*	100% Deductible waived.	100% Deductible waived.
Prophylaxis *Includes cleaning, scaling and polishing.* *Limited to 2 treatments per benefit period per Covered Person.* *Does not include periodontal cleanings (please see Section III for additional benefit coverage).*	100% Deductible waived.	100% Deductible waived.
Palliative emergency treatment and emergency oral examinations *Limited to reduction of fractures, stopping of bleeding and providing relief from pain.*	100% Deductible waived.	100% Deductible waived.
Dental X-rays • *Full mouth X-ray - Limited to 1 every 3 years per Covered Person.* • *Bitewings - Limited to 2 per benefit period per Covered Person.*	100% Deductible waived.	100% Deductible waived.
Topical fluoride applications *Limited to 2 treatments per benefit period for Covered Persons age 18 and under.*	100% Deductible waived.	100% Deductible waived.
Topical application of sealants *Limited to once per tooth per Calendar Year for Covered Persons age 15 and under, permanent molars only.* *Does not include extra charges for any replacement or repair of the sealant within 36 months of treatment.*	100% Deductible waived.	100% Deductible waived.
Space maintainers	100% Deductible waived.	100% Deductible waived.
Mouth guards (occlusal night guards) *Limited for treatment of bruxism.*	100% Deductible waived.	100% Deductible waived.

Expenses Deemed Incurred for Preventive Care Services	*Preventive Care Services expenses are deemed to be incurred: (1) By the person receiving the dental care and (2) as of the date dental care is performed.*

III. BASIC CARE SERVICES

COVERED EXPENSES AND PROVISIONS	In-Network	Out-of-Network
Basic Care Waiting Period	0 months	0 months
Basic Primary Care Services limited to: • *Fillings* • *Endodontics (root canals)* • *Repair of removable dentures* • *Repair of dentures or bridgework* • *Re-cementing of crowns, inlays and/or bridgework* • *Biopsies of oral tissue* • *Pulp vitality tests - Limited to once per 12 consecutive months per Covered Person.* • *Visits by a Dentist or Physician to a Covered Person's home when Dentally Necessary to render a covered dental service* • *Consultations* • *Oral surgery* • *Apicoectomy* • *Hemisection* • *General anesthesia administered in connection with a covered dental service only if administered by an individual licensed to administer general anesthesia, other than the Dentist or Physician performing the service for which such anesthesia is administered.* • *Injection of antibiotic drugs*	80%	80%
Extractions limited to: • *Simple extractions not requiring flap or bone removal* • *Surgical extractions, including erupted, soft tissue impacted, partial bony impacted, complete bony impacted teeth*	80%	80%
Periodontics (gum treatments) limited to: • *Gingivectomy and gingivoplasty* • *Gingival curettage* • *Osseous surgery, including flap entry and closure* • *Surgical periodontal examination* • *Muco-gingival surgery* • *Management of acute periodontal infection and oral lesions (including locally administered antibiotic treatments such as Arestin)* • *Periodontal cleanings (perio-prophylaxis)* • *Scaling and root planing (full mouth) - Limited to one per quadrant every 6 months per Covered Person.*	80%	80%

Expenses Deemed Incurred for Basic Care Services	*Basic Care Services expenses are deemed to be incurred: (1) By the person receiving the dental care and (2) as of the date dental care is performed. Exception: Expenses in the case of root canal therapy shall incur when work is begun on the tooth.*

IV. MAJOR CARE SERVICES

COVERED EXPENSES AND PROVISIONS	In-Network	Out-of-Network
Major Care Waiting Period	24 consecutive months for initial placement of dentures and bridgework*; 12 consecutive months for replacement of or addition of teeth to dentures or bridgework*; 0 months for other Major Care Services. * Unless the stated category exceptions/ conditions in this Section are met.	24 consecutive months for initial placement of dentures and bridgework*; 12 consecutive months for replacement of or addition of teeth to dentures or bridgework*; 0 months for other Major Care Services. * Unless the stated category exceptions/ conditions in this Section are met.
Gold foil	50%	50%
Gold or silver inlays and onlays, crowns (not part or bridge) *Limitations: Covered only if the tooth cannot be restored by a filling. For replacements, at least 5 years must have elapsed since the last placement.* *Excludes crowns for the primary purpose of periodontal splinting, altering vertical dimension, or restoring occlusion.*	50%	50%
Cast post and core *Limited to teeth that have had root canal therapy.*	50%	50%
Steel post and composite or amalgam	50%	50%
Initial dentures, full or partial, and bridgework, fixed and removable *Subject to the following: Initial placement to replace natural teeth which were missing prior to the effective date of this Plan will be covered only after the Covered Person has been covered under this Plan for at least 24 consecutive months.* *(Exception: The limitation is not applicable if the full or partial dentures or fixed and removable bridgework also includes replacement of a natural tooth extracted while covered under this Plan).*	50%	50%
Replacement of or addition of teeth to full or partial dentures or fixed bridgework *Subject to the following: Replacement or alteration will be covered only if the following condition exists:* *a) The original full or partial dentures or fixed bridgework cannot be made serviceable, and* *b) The Covered Person has been covered under this Plan for at least 12 consecutive months, and* *c) 5 years have elapsed since the last placement.* *(Exception: The limitation is not applicable if the replacement is made necessary by the initial placement of an opposing full denture).*	50%	50%

IV. MAJOR CARE SERVICES

COVERED EXPENSES AND PROVISIONS	In-Network Out-of-Network
Expenses Deemed Incurred for Major Care Services	*Except as provided in (1), (2) and (3) below, any expense or charge for Major Care Services will be deemed to be incurred as of the date the particular procedure is performed.* *1. Expenses for crowns, inlays, onlays or restorations will be deemed incurred on the first date of preparation of the tooth or teeth involved provided You (or Your Dependent) remain continuously insured during the course of treatment.* *2. Expenses for full or partial dentures or fixed bridgework will be deemed incurred on the date the final impression is taken provided You (or Your Dependent) remain continuously insured during the course of treatment.* *3. Expenses for rebase of an existing partial or complete denture will be deemed incurred on the first day of preparation of the rebase of such denture provided You (or Your Dependent) remain continuously insured during the course of treatment.*

V. ORTHODONTIC CARE SERVICES

COVERED EXPENSES AND PROVISIONS	In-Network	Out-of-Network
Orthodontic Care Services - *Limited to* ***Covered Persons age 18 and under*** *consisting of installations of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and conditions resulting from that malocclusion through correction of abnormally positioned teeth.*		
Orthodontic Care Waiting Period	0 months	0 months
Diagnostic services *Includes examination, study models, radiographs and all other diagnostic aids used to determine orthodontic needs.* *Limited to once per 5 years per Covered Person, commencing with the date of the Covered Person's initial visit to the Dentist or Physician.*	50%	50%
Active orthodontic treatment *Benefits will not be provided for more than 36 consecutive months.*	50%	50%
Retention treatment *Benefits will not be provided for more than 18 consecutive months.*	50%	50%
Replacement and/or repair of any appliance used during the Course of Orthodontic Treatment	Not Covered	Not Covered

Expenses Deemed Incurred for Orthodontic Care Services	*Orthodontic Care Services expenses are deemed to have been incurred as of the date on which the service or supply for which the charge is made is rendered or obtained, except with respect to charges for Orthodontic Treatment.* 1. *Charges incurred for diagnosis and evaluation or pre-orthodontic care preliminary to the Course of Orthodontic Treatment are limited to 25% of the total amount of Covered Expenses for the Course of Orthodontic Treatment.* 2. *With respect to each month of the Course of Orthodontic Treatment, a maximum monthly amount equal to the quotient of the total amount of Covered Expenses incurred for the Course Of Orthodontic Treatment (less the amount calculated above), divided by the maximum number of months necessary upon the installation of the first appliance to complete the Course of Orthodontic Treatment.*

DENTAL BENEFIT - EXCLUSIONS

No payment will be made under this Plan for expenses incurred by a Covered Person based on the below exclusions *(unless specifically stated within the Schedule of Covered Expenses and Provisions*):

1. for services and treatment unless they were prescribed by a Dentist or Physician, except for scaling or cleaning of teeth and topical application by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the Dentist or Physician;
2. for or in connection with an Injury for which the Employee or Dependent is entitled to benefits under any Workers' Compensation or similar law;
3. for care and treatment of an Injury arising out of, or in the course of, any employment for wage or profit;
4. for charges incurred on account of services received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar type of group;
5. for charges payable under any federal, state or local government program (unless legally required);
6. for services, supplies or treatment received in any government owned facility (unless legally required or when due to an emergency);
7. for charges which the Covered Person is not legally required to pay, or for charges which would not have been made if no coverage had existed;
8. for services, supplies or treatment for which no charge is applied or under this Plan is prohibited by any law to which the Covered Person is subject at the time expenses are incurred;
9. which are not Reasonable and/or in excess of Usual and Customary Charges;
10. for services or treatment which do not meet the standard of dental practice accepted by the American Dental Association;
11. which are for care or treatment which is experimental or investigational, according to accepted standards of dental practice;
12. which are for care or treatment which is not Dentally Necessary;
13. due to accidental Injury resulting from participation in the commission of an assault or felony;
14. for training, educational instructions or materials, even if they are performed or prescribed by a Dentist or Physician;
15. for charges in connection with dentistry for cosmetic purposes, including the alteration or extraction and replacement of sound teeth to change appearance;
16. for charges incurred on account of war, declared or undeclared, including armed aggression;
17. for expenses incurred on account of loss or theft of dentures, bridgework or appliances;
18. for installation, replacement or alteration of, or additions to, dentures or fixed bridgework, except as provided in the Schedule of Covered Expenses and Provisions;

19. for charges incurred for:
    a. all services in connection with implants;
    b. myofunctional therapy;
    c. mouth guards, except as provided in the Schedule of Covered Expenses and Provisions;
    d. oral hygiene, dietary or plaque control programs or other educational programs;
    e. duplicate prosthetic devices or appliances;
    f. porcelain veneered crowns or pontics placed on or replacing a tooth posterior to the second bicuspid, to the extent the charges exceed the charge that would have been covered under the Schedule of Covered Expenses and Provisions for acrylic veneered crowns or pontics; or
    g. crowns, appliances or restorations for the primary purpose of periodontal splinting, altering vertical dimension, or restoring occlusion (except as covered under orthodontic treatment);
20. for services, supplies or treatment which were ordered or started before coverage began, or after coverage ended;
21. for charges incurred by telephone consultation, failing to keep a scheduled visit, failing to complete a claim form or failing to provide medical records;
22. for supplies or appliances of the type normally intended for sport use;
23. for treatment of Temporomandibular Joint (TMJ) disorders;
24. for charges incurred in a hospital owned or operated by the United States Government or for services or supplies furnished by or for any other government unless payment is legally required;
25. for non-medical or non-dental expenses such as:
    a. preparing dental reports, itemized bills or charges for mailing;
    b. training, education instructions or materials, even if they are performed or prescribed by a Physician or Dentist; and
    c. legal fees and expenses incurred in obtaining medical or dental treatment;
26. for treatment provided by any person who ordinarily resides with the Covered Person;
27. for charges incurred outside of the United States if travel to such a location was for the primary purpose of obtaining dental services, drugs or supplies; or
28. for failure to provide any additional documentation or information as may be requested pursuant to the “Procedures for Filing Claims” section of this Plan.

VISION BENEFIT

Your Vision Network. If you enroll in the Medical Benefit, you will automatically be enrolled in the Vision Benefit. Under the Vision Benefit, you may use any licensed vision care provider. But, to get the biggest possible benefit from the Vision Benefit, you will need to go to a EyeMed network doctor for care. The Vision Benefit is designed to cover basic vision needs, such as routine eye exams and lenses, and is provided through EyeMed, an independent vision care company. The program is not designed to cover cosmetic eyewear, or medical or surgical treatment of eyes. EyeMed network doctors will also file the claim for benefits on your behalf. EyeMed network doctors are private practice vision care professionals who have contracted with EyeMed to provide services for pre-negotiated, discount fees. If you choose a non-EyeMed provider, your provider is not obligated to give you a discount on his services or the purchase of prescription eyewear. And, you pay for services at the time you receive them and then file a claim for benefits.

The plan covers routine eye exams, and materials (where an EyeMed doctor is used). There are no deductibles for you to meet before benefits are paid. Some services, however, require you to pay a copayment before EyeMed pays benefits. See the vision benefit booklet for more details.

VISION BENEFIT - SCHEDULE OF COVERED EXPENSES AND PROVISIONS

The Vision Benefit covers routine eye exams, and materials (where an EyeMed doctor is used). There are no deductibles for you to meet before benefits are paid. Some services, however, require you to pay a copayment before EyeMed pays benefits. The below chart is only a summary of Covered Expenses under the Vision Benefit, see the vision certificate of coverage for more details.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations and Exceptions
If you or your dependents (if applicable) need eye care	Eye Exam	$10.00 Copay	Reimbursed up to $45.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Glasses: $25.00 Copay (lenses and/or frames only); Contact Lens Exam/fitting up to $60 copay	Frames reimbursed up to $ 70 SV Lenses reimbursed up to $ 30.00 Bi-Focal Lenses reimbursed up to $ 50.00 Tri-Focal Lenses reimbursed up to $ 65.00 Lenticular Lenses reimbursed up to $100.00 ECL reimbursed up to $105.00	Frames covered every 24 month** Lenses covered every 12 months**

** Beginning with the first day of the Plan Year.

VISION BENEFIT - EXCLUSIONS

No payment will be made under this Plan for expenses incurred by a Covered Person based on the below exclusions *(unless specifically stated in the applicable certificate of coverage*):

1. frames, spectacle lenses, contact lenses or any other ophthalmic materials;
2. orthoptics or vision training and any associated supplemental testing;
3. surgery, and any pre- or post-operative services, except as an adnexal service included herein;
4. treatment for any pathological conditions;
5. an eye exam required as a condition of employment;
6. insulin or any medications or supplies of any type;
7. local, state and/or federal taxes, except where EyeMed is required by law to pay and
8. any other exclusion or limitation listed in the applicable Vision Benefit certificate of coverage.

DEFINITIONS

Certain words and terms used herein shall be defined as follows:

ADMINISTRATOR

Wellness Insurance Network C/O Marsh & McLennan Agency, LLC

AMBULATORY SURGICAL CENTER

Any private or public establishment with: a) an organized medical staff of Physicians; b) permanent facilities that are equipped and operated primarily for the purpose of performing Outpatient surgical procedures; c) 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.

ASC REIMBURSEMENT FEE SCHEDULE

The ambulatory surgical center reimbursement rate set by Centers for Medicare and Medicaid Services (CMS).

CALENDAR YEAR

That period of time commencing at 12:01 a.m. on January 1st and ending at 12:01 a.m. on the next succeeding January 1st. Each succeeding like period will be considered a new Calendar Year.

CASE MANAGEMENT PROGRAM

A program of medical management typically utilized in situations involving extensive and on-going medical treatment, which provides a comprehensive and coordinated delivery of services under the oversight of a medically responsible individual or agency. Such programs may provide benefits not normally covered under Plan provisions in lieu of in-Hospital treatment.

If, at any point in the progress of a given medical situation, after having considered the opinions of the Covered Person (and/or his legally responsible representatives), the Covered Person's Physician and/or other medical authorities, the Plan Administrator determines that the benefits of this Plan may be best utilized through the implementation of a Case Management Program, the Plan reserves the right to require that further benefits be provided only under the administration of such a program.

CLAIMS PROCESSOR

The entity providing consulting services to the Administrator in connection with the operation of the Plan and performing other functions, including processing of claims. See the Important Information section for the Claims Processor's contact information.

COURSE OF ORTHODONTIC TREATMENT

The period which begins when the first orthodontic appliance is installed on a Covered Person and ends when the last orthodontic appliance is removed.

COSMETIC SURGERY/TREATMENT

Surgery or treatment that is intended to improve the appearance of a patient or to preserve or restore a pleasing appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease (except when necessary to improve a deformity arising

from, or directly related to, a congenital abnormality, a personal Injury resulting from an accident or trauma, or a disfiguring disease).

COVERED EXPENSES

These are expenses for certain Hospital, dental, and vision services and supplies for the treatment of Injury or Illness. A detailed list of Covered Expenses is set forth in this booklet in the sections entitled "Schedule of Covered Expenses and Provisions."

COVERED PERSON / PLAN PARTICIPANT

A covered Employee or a covered Dependent. No person is eligible for benefits both as an Employee and as a Dependent under this Plan. When Member Libraries employ both husband and wife, any Dependent children may become covered hereunder only as Dependents of one spouse.

DEDUCTIBLE/CO-INSURANCE

The amount of eligible expense incurred in any Calendar Year, which must be satisfied by the Covered Person before benefits are paid. Upon receipt of satisfactory proof that a Covered Person has incurred covered expenses as a result of an Injury or Illness, the Plan, after deducting the Deductible amount shown in the Schedule of Covered Expenses and Provisions from the covered expenses first incurred during that Calendar Year, will pay benefits at the appropriate Co-Insurance level as shown in the Schedule of Covered Expenses and Provisions.

DENTALLY NECESSARY

Dental care services, supplies or treatment which, in the judgment of the attending Dentist or Physician, is appropriate and consistent with the diagnosis and which, in accordance with generally accepted dental standards, could not have been omitted without adversely affecting the patient's condition or the quality of dental care rendered.

DENTIST

A Doctor of Dental Surgery or a Doctor of Medical Dentistry.

DEPENDENTS

See the Eligibility and Enrollment section.

DOMESTIC PARTNER

See the Eligibility and Enrollment section and the Declaration of Domestic Partnership.

ELECTIVE SURGICAL PROCEDURE

Any non-emergency surgical procedure which may be scheduled at a patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions and which is performed while the patient is confined in a Hospital as an Inpatient or in an Ambulatory Surgical Center.

EMERGENCY ROOM SERVICES

"Emergency Room Services**"** is defined as, with respect to a Medical Emergency, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to Stabilize the patient.

EMPLOYEE

See the Eligibility and Enrollment section.

ENROLLMENT DATE

The first day of coverage or, if there is a Waiting Period communicated to Employees within the open enrollment materials, the first day after the date the Employee satisfies the Waiting Period.

EXTENDED CARE FACILITY

An institution (or a distinct part of an institution) which: (a) provides for Inpatients (1) 24-hour nursing care and related services for patients who require medical or nursing care, or (2) service for the rehabilitation of injured or sick persons; (b) has policies developed with the advice of (and subject to review by) professional personnel to cover nursing care and related services; (c) has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies; (d) requires that every patient be under the care of a Physician and makes a Physician available to furnish medical care in case of emergency; (e) maintains clinical records on all patients and has appropriate methods for dispensing drugs and biologicals; (f) has at least one registered professional nurse employed full time; (g) provides for periodic review by a group of Physicians to examine the need for admissions, adequacy of care, duration of stay and medical necessity of continuing confinement of patients; (h) is licensed pursuant to law, or is approved by appropriate authority as qualifying for licensing and is also approved by Medicare; (i) is not primarily a place for the aged, drug addicts, alcoholics, mentally retarded persons, or a place for rest, custodial or educational care or for the care of mental disorders.

FAMILY DEDUCTIBLE

If the amount of covered expenses incurred by family members and applied toward the Deductible totals the amount shown in the Schedule of Covered Expenses and Provisions, the Deductible amount shall be waived for all other members of that family unit for that Calendar Year.

GENDER NEUTRAL WORDING

A masculine pronoun in this document shall at all times be considered synonymous with a feminine pronoun unless the context indicates otherwise.

GENETIC INFORMATION

The term "genetic information" is defined under the Mental Health Parity and Addiction Equity Act, which generally includes 1) an individual's own genetic tests, 2) the genetic tests of family members of such individual, and 3) the manifestation of a disease or disorder in family members of such individual. The term “genetic information” also encompasses family medical history. The term "genetic information" additionally extends to genetic information of any fetus carried by a pregnant woman. With respect to an individual or family member utilizing an assisted reproductive technology, genetic information includes the genetic information of any embryo legally held by the individual or family member. The term “genetic information” further extends to dependents and family members defined as first-degree, second-degree, third-degree, or fourth-degree relatives of the individual. The term additionally includes participation in clinical research involving genetic services.

HOME HEALTH CARE AGENCY

A public or private agency that is primarily engaged in providing skilled nursing and other therapeutic services and is either (1) licensed or certified as a home health agency by the governing jurisdiction; or (2) certified as a home health agency by Medicare.

HOSPICE

A facility established to furnish terminally ill patients a coordinated program of Inpatient and home care of a palliative and supportive nature. A hospice must be approved as meeting established standards, including any legal licensing requirements.

HOSPITAL

An institution which meets all of the following requirements; (a) maintains permanent and full-time facilities for bed care of resident patients; (b) has a doctor in regular attendance; (c) continuously provides 24 hour a day nursing services by Registered Nurses (R.N.); (d) is primarily engaged in providing diagnostic and therapeutic services and facilities for medical and surgical care of Injuries or Illnesses on a basis other than a rest home, nursing home, convalescent home, or a home for the aged; (e) maintains facilities on the premises for surgery; (f) is operating lawfully as a Hospital in the jurisdiction where it is located; and (g) is either accredited by the Joint Commission on the Accreditation of Healthcare Organizations or is Medicare approved.

In addition, the term "Hospital" shall mean, as defined by Medicare, a Psychiatric Hospital, which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare; or, which meets the following requirements; (a) is licensed by the jurisdiction in which it operates; and (b) is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

HOSPITAL INTENSIVE CARE/CARDIAC CARE UNIT

Only a section, ward or wing within the Hospital which is distinguishable from other Hospital facilities because it (a) is operated solely for the purpose of providing room and board and professional care and treatment for critically ill patients, including constant observation and care by a Registered Nurse (R.N.) or other highly trained Hospital personnel, and (b) has special supplies and equipment necessary for such care and treatment, available on a standby basis for immediate use.

HOSPITAL SEMI-PRIVATE

The room and board charge is not to exceed the semi-private room rate. The difference between the semi-private room rate and the private room rate will be the patient's responsibility and will not apply to, or be affected by, any Out-of-Pocket Maximum provision. However, if 1) a private room is required due to Medical Necessity, or 2) the Hospital only has private rooms, the full private room charge will be considered.

ILLNESS

Only non-occupational sickness, disease, mental infirmity or pregnancy, all of which require treatment by a Physician.

INJURY

Only non-occupational bodily Injury which requires treatment by a Physician.

INPATIENT

A Covered Person shall be considered to be an "Inpatient" if he is treated at a Hospital and is confined for more than 18 consecutive hours. The term "Inpatient" shall also apply to those situations where "partial hospitalization" (defined as an on-going period of treatment involving full use of Hospital facilities excepting only room and board service) is recommended by the patient's Physician as an alternative to Hospital confinement.

LATE ENROLLMENT

An enrollment which takes place other than during the first period during which an individual was eligible for coverage, or other than during a period of Special Enrollment or Open Enrollment.

LIFETIME

Shall mean, "while covered under the Plan". Under no circumstances will the word "Lifetime" mean "during the lifetime of the Covered Person".

LIFETIME BENEFIT MAXIMUM

The maximum payable under any one Plan or Plan option that is aggregated with any and all other Lifetime Benefit Maximums for any other Plans or Plan options. Any payments made to any one Lifetime Benefit Maximum shall be considered applied to all Lifetime Benefit Maximums.

MEDICAL EMERGENCY

A **"**Medical Emergency**"** is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) a condition placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

MEDICALLY NECESSARY

Health care services, supplies or treatment which, in the judgment of the attending Physician, is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

MEDICARE DRG OR APC REIMBURSEMENT RATE

The inpatient and outpatient reimbursement rates set by Centers for Medicare and Medicaid Services (CMS).

MEMBER LIBRARY

A Member Library is a library that has entered into an agreement with the Administrator, in the form required by the Administrator, to participate in the Plan. The Administrator reserves the right to deem any Member Library ineligible to participate in the Plan where such Member Library's participation would be prohibited by law.

MENTAL/NERVOUS AND SUBSTANCE USE DISORDER SERVICES

Services for diagnoses that are listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered.

NAMED FIDUCIARY

The person or entity who has the complete authority to control and manage the operation and administration of the Plan. The Named Fiduciary for the Plan is the Administrator, who is the sponsor of this Plan.

In exercising its fiduciary responsibilities, the Administrator shall have sole, full and final discretionary authority to determine eligibility for benefits, review denied claims for benefits, construe and interpret all Plan provisions, construe disputed Plan terms, select managed care options, determine all questions of fact and law arising under this Plan, and to administer the Plan's subrogation and reimbursement rights. The Administrator shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

Any other individual or entity exercising any discretionary authority with respect to the Plan shall also be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

OPEN ENROLLMENT

Each year, a period of time may be designated as an "Open Enrollment" period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that an Employee or Dependent who did not enroll during their initial eligibility period may enroll in a Plan. Coverage will become effective on the date specified by the Member Library. See the Eligibility and Enrollment section at the beginning of this document for applicability, as well as Your Member Library for details.

OUT-OF-POCKET MAXIMUM

The "Out-of-Pocket Maximum" is the total amount of Deductibles and Co-Insurance or copays for which the Covered Person or covered family is responsible during the course of a Calendar Year. These amounts are shown in the "Schedule of Covered Expenses and Provisions". In no event will the Out-of-Pocket Maximum exceed the federal limit.

OUTPATIENT

A Covered Person shall be considered to be an "Outpatient" if he is treated at a Hospital and is confined less than 18 consecutive hours.

PHYSICIAN

A Physician who is duly qualified and licensed by the state in which he is resident to practice medicine, perform surgery and to prescribe drugs, or who is licensed to practice as a Dentist, podiatrist, chiropractor, psychologist, social worker or practitioner of healing arts, and who is practicing within the scope of his license.

PLACEMENT FOR ADOPTION

The assumption and retention of a legal obligation for total or partial support in anticipation of adoption.

PLAN

The Plan name is the Wellness Insurance Network Employee Benefits Plan.

PLAN ADMINISTRATOR

The entity responsible for the day-to-day functions and overall 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 WIN.

PLAN YEAR

The Plan Year is January 1 through December 31.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A legal order requiring the coverage of specified child(ren) under an individual's medical plan benefits. If Your employer determines that a separated or divorced spouse or any state child support or Medicaid agency has obtained a legal QMCSO (if applicable), or an otherwise valid court order requiring You to enroll your dependent, and Your current plan offers dependent coverage, You will be required to provide coverage for any child(ren) named in the order. If You do not enroll the child(ren), Your employer must enroll the child(ren) upon application from Your separated/divorced spouse, the state child support agency or Medicaid agency and withhold from Your pay Your share of the cost of such coverage. You may not drop coverage for the child(ren) unless You submit written evidence to Your employer that the child support order is no longer in effect. The plan may make benefit payments for the child(ren) covered by a valid court order directly to the custodial parent or legal guardian of such child(ren). Group health plans may not deny enrollment of a child under the health coverage of the child's parent on the ground that the child is born out of wedlock, not claimed as a dependent on the parent's tax return, or not in residence with the parent or in the applicable service area. Additional information concerning "QMCSO" procedures are available from the Plan Administrator at no charge upon request.

REASONABLE/REASONABLENESS

"Reasonable" and/or "Reasonableness" shall mean in the Plan Administrator's discretion, services or supplies, or charges for services or supplies, which are necessary for the care and treatment of Illness or Injury. Determination that charges or services/supplies are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and/or the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination may consider, but not be limited to, the findings and assessments of the following entities: (a) national medical associations, societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, services, supplies and/or charges must be in compliance with the Plan Administrator's policies and procedures relating to billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether services, supplies and/or charges are Reasonable based upon information presented to the Plan Administrator.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, and to identify charges and/or services that are not Reasonable, and therefore not eligible for payment by the Plan.

RECONSTRUCTIVE BREAST SURGERY COVERAGE

Medical benefits under the Plan will be administered according to the terms of the Women's Health and Cancer Rights Act of 1998. The Plan will provide to Covered Persons who are receiving Plan benefits in connection with such mastectomy coverage for: (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; and (3) prostheses and physical complications of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. The coverage will be subject to the terms of the Plan established for other coverage under the Plan, including the annual deductible and coinsurance provisions.

RETIREE

See the Eligibility and Enrollment section.

SECOND SURGICAL OPINION

Shall mean a written statement on the necessity for the performance of a covered surgical procedure. This Second Surgical Opinion must be given by a board-certified specialist who, by the nature of the Physician's specialty, qualifies the Physician to consider the surgical procedure being proposed and who is otherwise not associated with the surgeon who initially recommended the surgery.

SPECIAL ENROLLMENT

An enrollment which takes place during the 30-day period following the date of the event which triggers the Special Enrollment period. See Eligibility and Enrollment section for details.

STABILIZE

"Stabilize" means, with respect to a Medical Emergency, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

TREATMENT PLAN

A written report made by the Dentist or Physician describing the findings of that individual's examination of a Covered Person while the person is covered, and recommended treatment for the person's dental disease or defect or accident causing Injury to teeth.

USUAL AND CUSTOMARY

"Usual and Customary" (U&C) shall mean Covered Expenses which are identified by the Plan Administrator, taking into consideration the charge(s) which the provider most frequently bills the majority of patients for the service or supply, the cost to the provider for providing the service or supply, the prevailing range of charges billed in the same "area" by providers of similar training and experience for the service or supply, and/or the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, service, or supply for which a specific charge is made. To be Usual and Customary, the charge must be in compliance with the Plan Administrator's policies and procedures relating to billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other

medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Covered Person by a provider of services or supplies. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

WAITING PERIOD

The period of time before an individual is eligible to be covered under the terms of a group health plan. Any period before a Late Enrollment, Open Enrollment or Special Enrollment is not a Waiting Period.

YOU / YOURSELF

A covered Employee or a covered Dependent. No person is eligible for benefits both as an Employee and as a Dependent under this Plan. When Member Libraries employ both husband and wife, any Dependent children may become covered hereunder only as Dependents of one spouse.

EYEMED PREFERRED PROVIDER

An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with EyeMed to provide Vision Benefit benefits on behalf of Covered Persons of EyeMed.

PERSONNEL POLICIES

Except as required under the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act, the Member Library's current personnel policies regarding waiting periods, continuation of coverage or reinstatement of coverage shall apply during the following situations: leave of absence, layoff, reinstatement, hire or rehire.

NETWORK BENEFITS

Your Plan contains enhanced benefits through network providers. The name of the organization associated with these network providers is indicated on the front of Your ID card, along with instructions regarding where to file medical claims. Benefits are generally paid at a higher level when using network Hospitals and network Physicians than when using non-network providers. Please refer to the appropriate PPO Plan or HDHP Plan Schedule of Covered Expenses for benefits payable according to type of provider used. For on-line inquiry to locate a network provider near You, or to verify that a provider is in the PPO network, visit the website listed on Your ID card. For direct assistance in locating network providers, call the "Provider Referral Number" listed on Your ID card.

A Covered Person has a free choice of any provider for medical care. At any time, the Covered Person may choose any qualified provider with the understanding that different benefits may apply according to the provisions of the Plan.

CONTINUITY OF CARE

If you are currently covered by the Plan and your health care provider leaves the network, you can apply for continuity of care. If you have medical reasons preventing immediate transfer to a network provider, continuity of care benefits will allow you the option to request extended care from your out-of-network provider while paying in-network copayments or coinsurance until a safe transition can be made to an in-network provider. Continuity of care benefits are managed on a case-by-case basis.

If you are currently receiving treatment for covered healthcare services from a provider whose network status changes from in-network to out-of-network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care benefits, call BCBS for assistance.

PROCEDURES FOR FILING CLAIMS

Remember to Pre-Certify by calling the toll-free number shown on Your ID card if required by Your Plan.

KEY POINTS TO REMEMBER

The claims filing address You must use for filing all medical claims is shown on Your ID card.

1. Each bill should be itemized as to services, show payment status, and include the name of the patient, the Employee's social security number or unique identification number ("UID"), and the name and/or group number of the Member Library.
2. It is Your responsibility to see that all bills are submitted as indicated above. Proper payment cannot be made without the proper bills.
3. All charges, and corresponding requested documentation, must be submitted within the time frame specified in the Schedule of Covered Expenses and Provisions. Failure to do so will result in the denial of the charges.
4. From time to time, additional information may be requested to process Your claim. Any additional information, i.e. other insurance payments or information, completed claim forms or subrogation forms, accident details, police reports, etc. must be submitted by You or Your provider(s) when requested within the time frame specified in the Schedule of Covered Expenses and Provisions. Your failure to do so will result in the denial of the claim.
5. Only clean claims will be adjudicated by the Plan. A clean claim is one that is complete and accurate, does not require further information for processing from the provider, patient, or any other person or entity, and leaves no issues regarding the Plan's responsibility for payment.

FILING A HOSPITAL CLAIM

When a Covered Person is admitted as an Inpatient or is treated as an Outpatient, secure an itemized Hospital bill, including an admitting diagnosis. Check Your bill for any possible errors and then submit the charges as indicated above.

Always retain a copy of the hospital bill for Your records.

MISCELLANEOUS CLAIMS FILING CONSIDERATIONS

It is necessary to keep separate records of Your expenses with respect to each of Your Dependents and Yourself. The following items are important and should be carefully kept to be submitted with Your claim:

1. All Physician's bills should show the following:
   a. Name of patient and adequate membership information
   b. Dates and charges for services, and payment status of each
   c. Types of service rendered and procedure codes
   d. Diagnosis information
2. Prescription drug expenses should show the following:
   a. Name of patient and adequate membership information
   b. Prescription number and name of drug
   c. Cost of the drug and date of purchase. Cash register receipts and canceled

checks cannot be accepted for payment

d. Generic Drugs should be indicated on the drug bill

3. Bills for all other covered medical charges, such as for ambulance service, durable medical equipment, etc. should show the following:
    a. Name of patient and adequate membership information
    b. Date of service
    c. Charge and description of each service/item
    d. Diagnosis information

Always retain a copy of the bill for Your records. Claims must be filed within one year of the date charges for the services were incurred.

THIS PLAN AND MEDICARE

1. Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.
2. When an Employee becomes entitled to Medicare coverage and is still actively at work, the Employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
3. When a Dependent becomes entitled to Medicare coverage and the Employee is still actively at work, the Dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
4. If the Employee is still actively at work, and the Employee and/or Dependent are also enrolled in Medicare, this Plan shall pay as the primary plan. Medicare will pay as secondary plan.
5. If the Employee and/or Dependent elect to discontinue health coverage and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.

This section is subject to the terms of the Medicare laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The Plan is administered through the Office of the Administrator. The Administrator may choose to delegate claims processing authority to an independent Claims Processor experienced in claims processing. Fiscal records are maintained for a Plan Year ending as of the date specified under the Key Information section at the beginning of this document.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Administrator at the address specified in the Key Information section at the beginning of this document.

CLAIMS PROCEDURES

PROCEDURES REGARDING ELIGIBILITY

These procedures apply to claims for eligibility for coverage or enrollment in the Plan.

Filing a Claim

If you believe that you or your dependent is eligible for coverage under the Plan, you may file a claim in writing with the Plan Administrator or the Plan's Administrators delegate.

Initial Claim Decision

When an eligibility or enrollment claim is received, the Plan Administrator must notify you of its benefit determination within 90 days of the receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. You will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.

The Plan Administrator will send you a written notice of an adverse benefit determination. A denial of a claim will include:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan's appeal procedures and the time limits applicable to the appeal process.

Appealing an Eligibility or Enrollment Claim Denial

If you (or your duly authorized representative) believe that a denial is incorrect, you may request a full review by the Plan Administrator, or its delegate, within 60 days after your receipt of the denial of your claim. In connection with your appeal, you or your representative may submit

written comments, documents, records and other information relating to the claim. You also have the right to request copies of all relevant documents (free of charge).

The Plan Administrator will furnish you with a written decision providing the final determination of the appeal. The Plan Administrator's decision on appeal usually will be made within 60 days after receiving your appeal, unless special circumstances require an extension of an additional 60 days. If the period is extended, the Plan Administrator will notify you in writing of the extension within 60 days of receiving your appeal. The Plan Administrator's decision on review will be final and binding on you, your dependents and any other interested party. Your appeal notice will include:

- The specific reason or reasons for the appeal decision;
- Reference to the specific Plan provisions on which the determination is based; and
- A statement that you have the right to request access to and copies of all relevant Plan documents free of charge.

PROCEDURES REGARDING ADVERSE BENEFIT DETERMINATIONS

An explanation of benefits or other written or electronic notification will be provided by the Plan Administrator showing the calculation of the total amount payable for the claim, charges not payable, and the reason. If the claim is denied or reduced in whole or in part, it is considered an "Adverse Benefit Determination." An Adverse Benefit Determination also includes a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time of the rescission. An Adverse Benefit Determination is subject to the provisions detailed below. Claims must be filed within one year of the date charges for the services were incurred.

The Plan Administrator will notify the claimant of an Adverse Benefit Determination within 30 days after receipt of the claim. However, in certain cases an extension of up to 15 days may be utilized if the Plan Administrator determines that the extension is necessary due to matters beyond the control of the Plan and the claimant is notified prior to the expiration of the initial 30 day period of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If such an extension is necessary due to a failure of claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be given at least 45 days within which to provide the specified information.

A notice of Adverse Benefit Determination will include the following:

- Sufficient information to identify the claim involved, including the date(s) of service, health care provider, and claim amount.
- The specific reason or reasons for the Adverse Benefit Determination, as well as the Plan's standard that was used in denying the claim, if applicable, and including identifying denial codes and providing their meaning.
- Reference to specific Plan provisions on which the Adverse Benefit Determination is based.
- A description of any additional material or information necessary for the claimant to

perfect the claim and an explanation of why such material or information is necessary.

- A description of the Plan's first level appeal procedures and the time limits applicable to such procedures, including information on how to initiate an appeal, the contact information for the Illinois Office of Consumer Health Insurance (877-527-9431) to assist individuals with the first level claim and appeal process and second level (external) appeal process.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the notice of Adverse Benefit Determination; or the notice will contain a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be set forth in the notice of Adverse Benefit Determination, or the notice will contain a statement that such explanation will be provided free of charge upon request.

First Level Appeals Procedures

If You receive an Adverse Benefit Determination, You or Your authorized representative may appeal the determination by filing a written application with the Plan Administrator. In appealing an Adverse Benefit Determination, the Plan Administrator will provide You or Your authorized representative:

- The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
- Upon request and free of charge, reasonable access to, and copies of, all documents, records, the claim file, and other information relevant to the claim.
- A full and fair review that takes into account all comments, documents, records, and other information submitted by You relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. You must also be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan Administrator, as well as any new or additional rationale relied upon by the Plan Administrator in reaching its determination on appeal, that differs from that which the Plan Administrator relied on in its Adverse Benefit Determination. Such evidence and/or rationale must be provided as soon as possible and sufficiently in advance of the date on which the Plan Administrator's determination is required to be provided to give You a reasonable opportunity to respond prior to that date.
- A full and fair review that does not afford deference to the initial benefit determination and is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.

- In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, that the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that the health care professional consulted shall neither be an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
- Upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

A first level appeal must be filed within 180 days after the Adverse Benefit Determination is received. The Plan Administrator will notify You or Your authorized representative of its determination within 60 days after receipt of an appeal.

The Plan Administrator's determination:

- Will contain sufficient information to identify the claim involved, including the date(s) of service, health care provider, claim amount, denial codes and their meaning, as well as the Plan's standard used in denying the claim.
- Will be in writing, setting forth specific reasons for the decision and reference to the specific Plan provisions upon which the determination is based.
- Will contain a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
- Will contain a description of the Plan's second level (external) review process, including information on how to initiate a second level appeal, and the contact information for the Illinois Office of Consumer Health Insurance (877-527-9431) to assist individuals with the second level review process.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the determination; or the determination will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be set forth in the determination or the determination will contain a statement that such explanation will be provided free of charge upon request.

If the Plan does not strictly adhere to all the requirements of the first level claims and appeals process with respect to a claim, You are deemed to have exhausted the first level claims and appeals process. Accordingly, upon such a failure, You may initiate a second level (external) review and pursue any available remedies under applicable law.

Second Level (External) Appeals Procedure

If the Plan denies Your first level appeal, in whole or in part, such denial is called a Final Internal Adverse Benefit Determination. You or Your authorized representative may file a second level (external) appeal of the Final Internal Adverse Benefit Determination by filing a written application with the Illinois Department of Insurance. (However, You may not file a second level appeal of the Final Internal Adverse Benefit Determination to the extent that determination related to a failure to meet the requirements for eligibility under the terms of the Plan.)

To request a second level appeal, or for further information, contact the Director of the Illinois Department of Insurance at:

Illinois Department of Insurance
Office of Consumer Health Insurance
EXTERNAL REVIEW REQUEST
320 W. Washington Street
Springfield, IL 62767
(877) 850-4740 (toll-free phone number)
(217) 557-8495 (fax)
DOI.externalreview@illinois.gov

For a copy of the second level appeal claims procedures, contact the Plan Administrator.

Reversal of the Second Appeal decision.

Upon receipt of a notice of a final external review decision reversing the Final Internal Adverse Benefit Determination, the Plan must immediately pay the claim.

For questions about Your appeal rights or for assistance, You can contact the Illinois Office of Consumer Health Insurance at 877-527-9431.

ASSIGNMENT OF BENEFITS

The Plan will use its best efforts to recognize assignments of benefits from providers of services but is not bound by such assignments. Notwithstanding the foregoing, the Plan will not recognize any assignment of a Covered Person's right to bring a cause of action or otherwise initiate a legal proceeding arising from an adverse benefit determination. When payment is made directly to the Covered Person (with or without an assignment), it is solely the responsibility of the Covered Person to reimburse the provider.

CLAIM AUDIT

Once a written claim for benefits is received, the Plan Administrator, at its discretion, may elect to have such claim reviewed or audited for accuracy, Reasonableness and/or the Usual and Customary nature of charges as part of the adjudication process. This process may include, but not be limited to, identifying charges for items/services that may not be covered or may not have been delivered, duplicate charges and charges beyond the Reasonable and/or Usual and Customary guidelines as determined by the Plan Administrator.

COMPLIANCE

The Plan shall comply with all applicable federally mandated benefit laws and regulations pertaining to employee benefit plans. The intent of the Plan is to assure full compliance with all appropriate federal laws, rules and regulations and any act or omission through negligence or otherwise which results in any such violation, shall be construed as unintentional. The Claims Processor shall be fully discharged from liability under this Plan.

CONTACT INFORMATION FOR THE PLAN ADMINISTRATOR, NAMED FIDUCIARY, AND AGENT FOR SERVICE OF LEGAL PROCESS

Same as Administrator.

CONTRIBUTIONS

The benefits provided under the terms of this Plan are purchased through Member Library contributions. At the discretion of the Member Library, Employees may be required to contribute on a payroll deduction basis.

FUNDING

This Plan is a self-funded program for the benefits described in the Key Information section at the beginning of this document.

LIENS

To the full extent permitted by law, all rights and benefits accruing under this Plan shall be exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Employee.

This Plan is not a substitute for and does not affect any requirement for coverage by Workers' Compensation Insurance.

NO WAIVER

A failure to enforce any provision of this Plan shall not affect any right thereafter to enforce any such provision, nor shall such failure affect any right to enforce any other provision of this Plan.

PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract between the Administrator/Member Libraries and any Employee or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of any Member Library or to interfere with the right of a Member Library to discharge any Employee at any time.

PLAN AMENDMENT, MODIFICATION OR TERMINATION

The Administrator reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time and such amendment, modification, revocation or termination of the Plan shall be made by a written Plan endorsement signed by an authorized representative of the Administrator. Any such changes to the Plan, which affect participants, will be communicated to such participants by the Plan Administrator. Upon termination of the Plan, the rights of participants to benefits are limited to claims incurred and due up to the date of termination.

PROHIBITION ON RESCISSION

The Plan cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to an individual before coverage may be rescinded.

NON-DISCRIMINATION

In regard to the offering of coverage, the Plan will not discriminate against any individual on the basis of health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. No otherwise eligible individual will be refused the opportunity to enroll in the Plan due to participation in any particular activity, regardless of its hazardous nature. The Plan will not discriminate against similarly situated individuals in regard to eligibility or benefits (however, this does not limit the Plan's ability to treat participants classifiable through non-health related criteria as different groups in different ways.) The Plan will not knowingly discriminate against any individual on the basis of health factors. However, the Plan may impose coverage limits or exclusions on all similarly situated individuals which may have an effect on only some individuals.

REIMBURSEMENT AND SUBROGATION PROVISIONS

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Illness, Injury, or disability is caused in whole or in part by, or results from the acts or omissions of, a Covered Person or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

However, such payment of benefits by the Plan shall be made only if the Covered Person first provides a reimbursement agreement in writing. Notwithstanding the foregoing, payment of any claim in the absence of a signed reimbursement agreement shall not invalidate the obligation of the Covered Person to otherwise reimburse the Plan.

The Covered Person (including his attorney, and/or legal guardian of a covered minor or incapacitated individual) agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or his attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Covered Person settles, recovers, or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or who may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is only one, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness, Injury or disability to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may, at its discretion, in its own name or in the name of the Covered Person commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person fails to file a claim or pursue damages against:

a) the responsible party, its insurer, or any other source on behalf of that party;

b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

c) any policy of insurance from any insurance company or guarantor of a third party;

d) worker's compensation or other liability insurance company; or

e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

The Plan shall have the specific right of first recovery ("reimbursement"), and as such, shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the

judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person, or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH

In the event that the Covered Person dies as a result of his injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

OBLIGATIONS

It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:

a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

b) to provide the Plan with pertinent information regarding the Illness, Injury, or disability, including accident reports, settlement information and any other requested additional information;

c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights, including providing to the Plan an executed reimbursement agreement;

d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

f) to not settle or release, without the prior consent of the Plan, any claim to the

extent that the Covered Person may have against any responsible party or Coverage.

If the Covered Person and/or his attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's cooperation or adherence to these terms.

OFFSET

Failure by the Covered Person and/or his attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits, and any funds, or payments due under this Plan on behalf of the Covered Person may be withheld until the Covered Person satisfies his obligation.

MINOR STATUS

In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine acceptability of any applicant for participation in the Plan.

In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

RIGHTS OF RECOVERY

Whenever payments have been made by the Plan which are in excess of the maximum amount allowed under the Plan or are otherwise not covered under any provision of the Plan, the Claims Processor or Plan Administrator shall have the right to recover such payments from among one or more of the following: any persons to, for or with respect to whom such payments were made; any providers of service; any insurance companies or any other organizations. Current benefit payments may be reduced to satisfy outstanding reimbursements.

SEVERABILITY

Should any provision of this Summary Plan Description be declared invalid or illegal for any reason, such invalidity or illegality shall not affect the remaining portions of the Summary Plan Description. Any remaining portions shall remain in full force and effect, as if this Summary Plan Description did not contain the invalid or illegal provision.

SUBMISSION OF CLAIM

All charges, and corresponding requested documentation, must be submitted by the date specified in the Schedule of Covered Expenses and Provisions. Failure to do so will result in the denial of the charges.

SUMMARY OF MATERIAL MODIFICATIONS

Where required by law, Covered Persons shall be furnished summary descriptions of material modifications in the terms of this Plan and changes in the information required to be included in the Summary Plan Description pertaining to this Plan not later than 210 days after the end of the Plan Year in which the change is adopted. However, in the case of any modification or change that is a material reduction in covered services or benefits provided under the Plan, Covered Persons will be furnished a summary of such modification or change not later than 60 days after the adoption of the modification or change, unless the Administrator provides summaries of modifications or changes at regular intervals of not more than 90 days.

SYSTEM FOR PROCESSING CLAIMS

Claims will be processed on the following basis: 1) first, any non-covered services or services in excess of Plan provisions will be subtracted from billed charges; 2) then, Reasonable and/or Usual and Customary limitations will be applied (if applicable); 3) then, any reduction authorized by agreements with provider networks will be applied to charges from network providers; and 4) then, any Deductible/Co-Insurance or uncollected co-pays will be deducted from the remaining eligible amount prior to payment.

TYPE OF ADMINISTRATION

The Plan is self-administered by the Plan Administrator. The Plan Administrator has hired a Claims Processor to process claims and provide consulting services and ministerial functions.

COORDINATION OF BENEFITS (COB)

The Coordination of Benefits provision is intended to prevent payments of benefits that exceed expenses. It applies when any other plan or plans also cover the person covered by this Plan. 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 pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. Only the amount paid by the Plan will be charged against the Plan maximums. See Schedule of Covered Expenses and Provisions to determine the type of Coordination of Benefits this Plan provides.

To coordinate benefits, it is necessary to determine in what order the benefits of various Plans are payable. This is determined as follows:

1. If a plan does not have a provision for the coordination of benefits, its benefits are payable before this Plan.
2. If a plan covers a person other than as a Dependent, its benefits are payable before this Plan. This includes Medicare covering a person other than as a Dependent (e.g. a retired Employee) and any Medicare Supplement Plan. However, in all instances, federal regulations regarding Medicare as a secondary payer will apply.
3. If a plan covers an active Employee, its benefits are payable before this Plan. This order of determination does not supersede No. 2 above.
4. If an individual is covered as a Dependent under 2 separate plans, the benefits are payable first under the Employee's plan having the earliest birthday in a Calendar Year. However, if the Dependent is a child whose parents are separated or divorced, the "birthday rule" does not apply. The following order to determination will apply:

   If the parent with custody has not remarried:

   a) The plan of the parent with custody is primary.
   b) The plan of the parent without custody is secondary.

   If the parent with custody has remarried:

   a) The plan of the parent with custody is primary.
   b) The plan of the stepparent with custody is secondary.
   c) The plan of the parent without custody is tertiary (third).

   There may be a court decree that makes one parent financially responsible for the health care expenses incurred by the child. If a plan covers the child as a Dependent of that parent, its benefits are payable before those of a plan that covers the child as a Dependent of the parent without financial responsibility.
5. If a plan covers an individual who is also allowed to be covered by this Plan pursuant to COBRA continuation coverage, its benefits are payable before this Plan.
6. If items 1, 2, 3, 4 or 5 do not apply, the benefits of a plan that has covered the person for the longest period of time will be payable before those of the other plan.

To the extent that the Plan would be secondary to Medicare, if a Covered Person is eligible for Medicare Part A and/or Part B and does not elect to enroll in such Medicare coverage, then Plan benefits will be coordinated based on an estimate of what Medicare would have paid, regardless of whether benefits are actually received from Medicare.

Any other "plan" means and includes, but is not necessarily limited to the following: any policy, contract or other arrangement for group insurance benefits, including any Hospital or medical service organization plan or other service or prepayment plan arranged through any employer, union, trustee, Employee benefit association, government agency or professional association; or any homeowner's policy or other policy providing liability coverage; or any coverage for students sponsored by or provided through a school or other educational institution; or any coverage

provided by a licensed Health Maintenance Organization (HMO); or any benefits payable under Medicare (to the extent permitted by law); or any government program or any coverage provided by statute.

The term "plan" shall also mean any mandatory "no-fault" automobile insurance coverage providing benefits under a medical expense reimbursement provision for Hospital, medical, or other health care services and treatment because of accidental bodily Injuries arising out of a motor vehicle accident; and any other payment received under any automobile policy.

To administer this provision, the Administrator has the right to:

1. Release or obtain data needed to determine the benefits payable under this provision
2. Recover any sum paid above the amount that is required by this provision and
3. Repay any party for a payment made by the party, when the Administrator should have made the payment.

COMPLIANCE REGULATIONS

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., Your Physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.
In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain pre-certification. For information on pre-certification, contact Your Plan Administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) MASTECTOMY BENEFITS NOTICE

Federal law requires this Plan to provide the following benefits for elective breast reconstruction in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications in all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient. Such coverage is subject to all other Plan terms and limitations.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you are eligible for health coverage under the Plan, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. An updated list of states with premium assistance programs, along with program contact information, is available athttp://www.dol.gov/ebsa/chipmodelnotice.doc.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse/permanent partner) because of other health plan coverage, you may in the future be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage, provided that you request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your eligible dependents at that time. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator.

SOURCE OF INJURY RESTRICTIONS

The Plan will not limit coverage for Injuries or Illnesses resulting from 1) domestic violence, or 2) self-inflicted injury or attempted suicide. Further, the Plan will not limit coverage for Injuries or Illnesses resulting from participation in any activity if such Illness or Injury is as a result of a physical or mental condition.

WELLNESS VS. RISK FACTORS

The Plan will not charge Covered Persons who have adverse health factors, or who participate in certain adverse lifestyle activities, more than those similarly situated Covered Persons who do not have such factors or participate in such activities.* Further, the Plan will not provide rewards to Covered Persons who participate in, or meet the requirements of, positive lifestyle activities in excess of what is offered to those similarly situated Covered Persons who do not participate in, or meet the requirements of, such activities.*

* Except as such differential treatment is allowed through the incorporation of wellness program(s) meeting federally approved guidelines.

FAMILY MEDICAL LEAVE ACT (FMLA)

The following applies to companies with 50 or more employees

If the Covered Person is entitled to, and elects to take, a family or medical leave solely under the terms of the Family and Medical Leave Act of 1993 (FMLA), the Covered Person and his covered Dependents shall continue to be covered under this Plan while the Covered Person is absent from work on an FMLA leave as if there were no interruption of active employment. Provided the applicable premium is paid, such coverage will continue until the earlier of the expiration of such leave or the date notice is given to the Administrator that the Covered Person does not intend to return to work at the end of the FMLA leave.

The Covered Person may choose not to retain health coverage during the FMLA leave. If he returns to active working status on or before the expiration of the leave, he is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. (Coverage will be reinstated without any additional qualification requirements imposed by this Plan. This Plan's provisions with respect to pre-existing conditions, Deductibles and percentage of payments will apply on the same basis as they did prior to the FMLA leave.)

MILITARY LEAVES

If You are absent from work due to military service, You may elect to continue coverage under the Plan (including coverage for enrolled Dependents) for up to 24 months from the first day of absence (or, if earlier, until the day after the date You are required to apply for or return to active

employment with a Member Library under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)). Your contributions for continued coverage will be the same as for a COBRA beneficiary, except that, if You are absent for 30 days or less, Your contribution will be the same as for similarly situated active participants in the Plan.

Whether or not You continue coverage during military service, You may reinstate coverage under the Plan on Your return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Plan, except to the extent that You had not fully completed any required waiting period prior to the start of military service.

GENETIC INFORMATION

The Plan may not adjust premium or contribution amounts for those covered under the Plan on the basis of genetic information. The Plan may also not request, require or purchase genetic information for underwriting purposes (or in connection with any individual prior to such individual's enrollment under the Plan). The term "underwriting" covers rules relating to the determination of eligibility (including enrollment and continued eligibility) for Plan benefits or coverage, the computation of premium or contribution amounts, application of pre-existing condition exclusions and any activities relating to the creation, renewal, or replacement of the Plan.

This Plan is prohibited from requesting or requiring genetic testing on the part of an individual or his family members. Genetic tests include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

The Plan may obtain and use the results of a genetic test when making payment determinations (so long as only the minimum amount of information is utilized necessary for the determination).

A plan may request (but not require) that a participant undergo a genetic test if 1) the plan clearly indicates that compliance is voluntary, and that noncompliance will have no effect on enrollment status or premium/contribution amounts, 2) no genetic information collected is used for underwriting purposes, and 3) the plan notify the applicable federal government agency that the plan is conducting activities pursuant to this exception and includes a description of the activities.

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You when You would otherwise lose Your group health coverage. It can also become available to other members of Your family who are covered under the Plan when they would otherwise lose their group health coverage. Although not required by COBRA, the Plan will extend continuation coverage that is similar to COBRA to Domestic Partners and children of Domestic Partners.

For additional information about Your rights and obligations under the Plan and under federal law, You should review this Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, Your spouse, and Your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because either one of the following qualifying events happens:

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

If You are the spouse of an employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because any of the following qualifying events happens:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that

bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer (if the Plan provides retiree coverage), or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE WRITTEN NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), You must notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice in writing to the Plan Administrator at the address indicated in the Key Information section at the beginning of this document. IF YOU, YOUR SPOUSE OR YOUR DEPENDENT FAIL TO PROVIDE TIMELY WRITTEN NOTICE TO THE PLAN ADMINISTRATOR AFTER A DIVORCE, LEGAL SEPARATION OR LOSS OF DEPENDENT CHILD ELIGIBILITY, THE RIGHT TO ELECT TO PURCHASE COBRA CONTINUATION COVERAGE IS WAIVED.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), Your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

If the Plan has retiree coverage, and if the employer from whose employment the covered retiree retired files a Chapter 11 bankruptcy reorganization, and the covered retiree loses coverage within one year before or after the bankruptcy filing, a qualifying event has occurred. That is, COBRA coverage could continue until the death of the retiree, or until the death of a covered surviving spouse of a deceased retiree, or for 36 months from the retiree's death in the case of a spouse or dependent.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation

coverage generally lasts for only up to a total of 18 months. There are 2 ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of continuation coverage. A copy of the determination of disability by the Social Security Administration must be sent to the Plan Administrator at the address indicated in the Key Information section at the beginning of this document within 60 days after the date the determination is issued and before the end of the 18-month maximum coverage period that applies to the qualifying event. Any individual who is either the employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the employee or qualified beneficiary, may send the written notice to the Plan Administrator. Such individual(s) must further notify the Plan Administrator in writing within 30 days after a determination has been made that the person is no longer disabled. The Plan may require the payment of an amount that is up to 150 percent of the applicable premium for the period of extended coverage as long as the disabled individual is included in the extended coverage period.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the date of the first qualifying event, if notice of the second qualifying event is properly sent in writing to the Plan Administrator at the address indicated in the Key Information section at the beginning of this document. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated. This extension may also be available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, You must make sure that the Plan Administrator is sent written notice of the second qualifying event within 60 days of the second qualifying event.

ELECTION OF COBRA CONTINUATION COVERAGE

There is no requirement to show evidence of good health in order to choose COBRA coverage. However, the COBRA participant will have to pay all of the cost to the Plan for COBRA coverage, and may be charged an additional 2% administrative fee. A 50% administrative fee may be charged if coverage is extended due to a disability and the disabled individual is in the extended coverage period.

Any individual eligible for COBRA coverage has 60 days from the later of the date of the COBRA notification letter or the date coverage is lost to elect such coverage. Also, an eligible individual electing COBRA coverage has 45 days from the date of election to pay the initial premium. THEREAFTER, PAYMENT IS DUE ON THE FIRST DAY OF EACH MONTH WITH A 30-DAY GRACE PERIOD.

If a qualifying event occurs, the Plan Administrator will notify those eligible individuals of the procedure for electing COBRA coverage and the cost of such coverage.

In considering whether to elect continuation coverage, You should take into account that a failure to continue Your group health coverage will affect Your future rights under federal law. First, You can lose the right to avoid having pre-existing condition exclusions applied to You by other group health plans if You have more than a 63-day gap in health coverage, and election of continuation coverage may help You not have such a gap. Second, You will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if You do not get continuation coverage for the maximum time available to You. Finally, You should take into account that You have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which You are otherwise eligible (such as a plan sponsored by Your spouse's employer) within 30 days after Your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if You get continuation coverage for the maximum time available to You.

IF THE EMPLOYEE, SPOUSE OR DEPENDENT FAILS TO EXERCISE THE ELECTION WITHIN THE 60-DAY PERIOD, THE RIGHT TO ELECT TO PURCHASE COBRA COVERAGE IS WAIVED. IF ANY PREMIUM PAYMENT IS NOT MADE WITHIN THE TIME FRAMES SPECIFIED ABOVE, COBRA COVERAGE WILL BE FORFEITED.

If coverage under the Plan is modified for active Employees, coverage shall also be modified in the same manner for COBRA coverage participants. COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

TERMINATION OF COBRA CONTINUATION COVERAGE

Certain events can cut short the 18, 29 or 36 month continuation periods. They are:

1. The Administrator's termination of the Plan.
2. The COBRA participant first becomes, after the date of election, entitled to Medicare benefits.
3. The COBRA participant first becomes, after the date of election, covered under another group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such participant.
4. The COBRA participant fails to pay the premium in a timely manner.

In no event shall coverage extend beyond the applicable maximum period.

TRADE ACT OF 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the applicable tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If You have questions about these new tax provisions, You may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. Information about the Trade Act is also available at www.doleta.gov/tradeact.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified under Plan Contact Information in the Key Information section at the beginning of this document. For more information about Your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws

affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

PLAN CONTACT INFORMATION

If there are any questions regarding COBRA Continuation Coverage under the Plan, please contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document.

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS")

ISSUED PURSUANT TO

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA")

1. Disclosure of Summary Health Information to the Plan Sponsor

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

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

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

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

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

b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree in writing to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or

disclosures provided for of which the Plan Sponsor becomes aware;

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

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

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

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

i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

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

   i. The access to and use of PHI by the individuals described in the Eligibility and Enrollment section at the beginning of this document shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

   ii. In the event any of the individuals described in the Eligibility and Enrollment section do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" functions are activities that would meet the definitions of treatment, payment and health care operations. "Plan Administration" functions include, but are not limited to quality assurance, claims processing, auditing, monitoring, management, stop loss underwriting, stop loss claims filing, eligibility information requests, medical necessity reviews, certain appeal determinations, utilization review, case management and disease management. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

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

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating

in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

4. Other Disclosures and Uses of PHI

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

NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices ("Notice") sets out this Plan's legal obligations concerning a Covered Person's protected health information and describes a Covered Person's rights to access and control that protected health information. This Notice also describes how protected health information may be used or disclosed by this Plan to carry out treatment, payment, health care operations and for other purposes that are permitted or required by law.

Protected health information ("PHI") is individually identifiable health information, including demographic information, collected from a Covered Person or created or received by a health care provider, a health plan, an employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (1) a Covered Person's past, present or future physical or mental health or condition; (2) the provision of health care to a Covered Person; or (3) the past, present or future payment for the provision of health care to a Covered Person.

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

If You have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document:

THE PLAN'S RESPONSIBILITIES

The Plan is required by law to maintain the privacy of a Covered Person's PHI. The Plan is obligated to provide You with a copy of this Notice of the Plan's legal duties and of its privacy practices with respect to PHI, and the Plan must abide by the terms of this Notice. The Plan reserves the right to change the provisions of this Notice and make the new provisions effective for all PHI that is maintained. If the Plan makes a material change to this Notice, a revised Notice will be mailed to the address that the Plan has on record.

To the extent required by the HIPAA Privacy Rule, when using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

Genetic information shall be treated as health information pursuant to the Health Insurance Portability and Accountability Act. The use or disclosure by the Plan of protected health information that is genetic information about an individual for underwriting purposes under the Plan shall not be a permitted use or disclosure.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following is a description of how the Plan is most likely to use and/or disclose a Covered Person's PHI.

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The Plan has the right to use and disclose a Covered Person's PHI for all activities that are included within the definitions of "treatment, payment and health care operations" as described in the HIPAA Privacy Rule.

TREATMENT

The Plan may use or disclose PHI so that a Covered Person may seek treatment. Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to consultations and referrals between one or more of a Covered Person's providers. For example, the Plan may disclose to a treating specialist the name of a Covered Person's primary care physician so that the specialist may request medical records from that primary care physician.

PAYMENT

The Plan may use or disclose PHI to pay claims for services provided to a Covered Person and to obtain stop-loss reimbursements, if applicable, or to otherwise fulfill the Plan's responsibilities for coverage and providing benefits. For example, the Plan may disclose PHI when a provider requests information regarding a Covered Person's eligibility for coverage under this Plan, or the Plan may use PHI to determine if a treatment that was received was medically necessary.

HEALTH CARE OPERATIONS

The Plan may use or disclose PHI to support its business functions. These functions include, but are not limited to quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning and business development. For example, the Plan may use or disclose PHI: (1) to provide a Covered Person with information about a disease management program; (2) to respond to a customer service inquiry from a Covered Person or (3) in connection with fraud and abuse detection and compliance programs.

BUSINESS ASSOCIATES

The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf or to provide certain types of services. To perform these functions or to provide the services, the Plan's Business Associates will receive, create, maintain, use or disclose PHI, but only after the Plan requires the Business Associates to agree in writing to contract terms designed to appropriately safeguard PHI. For example, the Plan may disclose PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation or pharmacy benefit management. Examples of the Plan's Business Associates would be its third party administrator, broker, preferred provider organization and utilization review vendor.

OTHER COVERED ENTITIES

The Plan may use or disclose PHI to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care provider when needed by the provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations in the areas of fraud and abuse detection or compliance, quality assurance and improvement activities or accreditation, certification, licensing or credentialing. This also means that the Plan may disclose or share PHI with other insurance carriers in order to coordinate benefits, if a Covered Person has coverage through another carrier.

PLAN SPONSOR

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. Also, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or types of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with the HIPAA Privacy Rule.

POTENTIAL IMPACT OF STATE LAW

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

OTHER POSSIBLE USES AND DISCLOSURES OF PHI

The following is a general description of other possible ways in which the Plan may (and is permitted to) use and/or disclose PHI.

REQUIRED BY LAW

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

PUBLIC HEALTH ACTIVITIES

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

HEALTH OVERSIGHT ACTIVITIES

The Plan may disclose PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (1) the health care system; (2) government benefit programs; (3) other government regulatory programs and (4) compliance with civil rights laws.

ABUSE OR NEGLECT

The Plan will disclose PHI to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, the Plan will disclose to a governmental entity, authorized to receive such information, a Covered

Person's PHI if there is reason to believe that the Covered Person has been a victim of abuse, neglect, or domestic violence.

LEGAL PROCEEDINGS

The Plan may disclose PHI: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) and (3) in response to a subpoena, a discovery request, or other lawful process, once the Plan has met all administrative requirements of the HIPAA Privacy Rule. For example, the Plan may disclose PHI in response to a subpoena for such information, but only after first meeting certain conditions required by the HIPAA Privacy Rule.

LAW ENFORCEMENT

Under certain conditions, the Plan also may disclose PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person or (3) it is necessary to provide evidence of a crime.

CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS, AND ORGAN DONATION

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

RESEARCH

The Plan may disclose or use a "limited date set" or PHI for certain research purposes, with prior authorization

TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY

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

MILITARY ACTIVITY AND NATIONAL SECURITY, PROTECTIVE SERVICES

Under certain conditions, the Plan will disclose PHI if Covered Persons are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If Covered Persons are members of foreign military service, the Plan may disclose, in certain circumstances, PHI to the foreign military authority. The Plan also may disclose PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons or heads of state.

INMATES

If a Covered Person is an inmate of a correctional institution, the Plan may disclose PHI to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to the Covered Person; (2) the Covered Person's health and safety and the health and safety of others or (3) the safety and security of the correctional institution.

WORKERS' COMPENSATION

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

OTHERS INVOLVED IN YOUR HEALTH CARE

Using its best judgment, the Plan may make PHI known to a family member, other relative, close personal friend or other personal representative that the Covered Person identifies. Such use will be based on how involved the person is in the Covered Person's care or in the payment that relates to that care. The Plan may release information to parents or guardians, if allowed by law.

The Plan also may disclose PHI to an entity assisting in a disaster relief effort so that a Covered Person's family can be notified about his condition, status, and location.
If a Covered Person is not present or able to agree to these disclosures of PHI, then, using its professional judgment, the Plan may determine whether the disclosure is in the Covered Person's best interest.

REQUIRED DISCLOSURES OF PHI

The following is a description of disclosures that the Plan is required by law to make.

DISCLOSURES TO THE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Plan is required to disclose PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

DISCLOSURES TO COVERED PERSONS

The Plan is required to disclose to a Covered Person most of the PHI in a "designated record set" when that Covered Person requests access to this information. Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's health care benefits. The Plan also is required to provide, upon the Covered Person's request, an accounting of most disclosures of his PHI that are for reasons other than treatment, payment and health care operations and are not disclosed through a signed authorization.

The Plan will disclose a Covered Person's PHI to an individual who has been designated by that Covered Person as his personal representative and who has qualified for such designation in accordance with relevant state law. However, before the Plan will disclose PHI to such a person, the Covered Person must submit a written notice of his designation, along with the documentation that supports his qualification (such as a power of attorney).

Even if the Covered Person designates a personal representative, the HIPAA Privacy Rule permits the Plan to elect not to treat that individual as the Covered Person's personal representative if a reasonable belief exists that: (1) the Covered Person has been, or may be, subjected to domestic violence, abuse or neglect by such person; (2) treating such person as his personal representative could endanger the Covered Person, or (3) the Plan determines, in the exercise of its professional judgment, that it is not in its best interest to treat that individual as the Covered Person's personal representative.

OTHER USES AND DISCLOSURES OF PHI

Other uses and disclosures of PHI that are not described previously will be made only with a Covered Person's written authorization. This includes disclosures of PHI containing

psychotherapy notes (except as necessary for the Health Plans' treatment, payment and health care operating purposes), for many marketing purposes and for any sale of your PHI, each as defined under HIPAA regulations. If the Covered Person provides the Plan with such an authorization, he/she may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that has already been used or disclosed, relying on the authorization.

A COVERED PERSON'S RIGHTS

The following is a description of a Covered Person's rights with respect to PHI:

RIGHT TO REQUEST A RESTRICTION

A Covered Person has the right to request a restriction on the PHI the Plan uses or discloses about him/her for treatment, payment or health care operations.
The Plan is not required to agree to any restriction that a Covered Person may request. If the Plan does agree to the restriction, it will comply with the restriction unless the information is needed to provide emergency treatment.

A Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person directs his request for restriction to this individual or office so that the Plan can begin to process Your request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Person where to send the request when the Covered Person's call is received. In this request, it is important that the Covered Person states: (1) the information whose disclosure he/she wants to limit and (2) how he/she wants to limit the Plan's use and/or disclosure of the information.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

If a Covered Person believes that a disclosure of all or part of his PHI may endanger him/her, that Covered Person may request that the Plan communicates with him/her regarding PHI in an alternative manner or at an alternative location. For example, the Covered Person may ask that the Plan only contact the Covered Person at a work address or via the Covered Person's work e-mail.

The Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the request for confidential communications is addressed to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Person where to send a written request upon receiving a call. This written request should inform the Plan: (1) that he/she wants the Plan to communicate his PHI in an alternative manner or at an alternative location and (2) that the disclosure of all or part of this PHI in a manner inconsistent with these instructions would put the Covered Person in danger.

The Plan will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of a Covered Person's PHI could endanger that Covered Person. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and

is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting a Covered Person's request, he/she will be required to provide the Plan information concerning how payment will be handled. For example, if the Covered Person submits a claim for payment, state or federal law (or the Plan's own contractual obligations) may require that the Plan disclose certain financial claim information to the Plan Participant under whose coverage a Covered Person may receive benefits (e.g., an Explanation of Benefits "EOB"). Unless the Covered Person has made other payment arrangements, the EOB (in which a Covered Person's PHI might be included) will be released to the Plan Participant.

Once the Plan receives all the information for such a request (along with the instructions for handling future communications), the request will be processed usually within 2 business days or as soon as reasonably possible.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI may be disclosed (such as through an EOB). Therefore, it is extremely important that the Covered Person contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document as soon as the Covered Person determines the need to restrict disclosures of his PHI.

If the Covered Person terminates his request for confidential communications, the restriction will be removed for all of the Covered Person's PHI that the Plan holds, including PHI that was previously protected. Therefore, a Covered Person should not terminate a request for confidential communications if that person remains concerned that disclosure of PHI will endanger him/her.

RIGHT TO INSPECT AND COPY

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

To inspect and copy PHI that is contained in a designated record set, the Covered Person must submit a request by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person contact this individual or office to request an inspection and copying so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay the processing of the request. If the Covered Person requests a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with that request.

The Plan may deny a Covered Person's request to inspect and copy PHI in certain limited circumstances. If a Covered Person is denied access to information, he/she may request that the denial be reviewed. To request a review, the Covered Person must contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. A licensed health care professional chosen by the Plan will review the Covered Person's request and the denial. The person performing this review will not be the same one who denied the Covered Person's initial request. Under certain conditions, the Plan's denial will not be reviewable. If this event occurs, the Plan will inform the Covered Person through the denial that the decision is not reviewable.

RIGHT TO AMEND

If a Covered Person believes that his PHI is incorrect or incomplete, he/she may request that the Plan amend that information. The Covered Person may request that the Plan amend such information by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. Additionally, this request should include the reason the amendment is necessary. It is important that the Covered Person direct this request for amendment to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

In certain cases, the Plan may deny the Covered Person's request for an amendment. For example, the Plan may deny the request if the information the Covered Person wants to amend is not maintained by the Plan, but by another entity. If the Plan denies the request, the Covered Person has the right to file a statement of disagreement with the Plan. This statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include this statement.

RIGHT OF AN ACCOUNTING

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

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

A Covered Person may request an accounting by submitting a request in writing to the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person direct the request for an accounting to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request. A Covered Person's request may be for disclosures made up to 6 years before the date of the request. The first list requested within a 12-month period will be free. For additional lists, the Plan may charge for the costs of providing the list. The Plan will notify the Covered Person of the cost involved and he/she may choose to withdraw or modify the request before any costs are incurred.

RIGHT TO RECEIVE NOTIFICATION OF BREACHES

The Plan must notify a Covered Person within 60 days of discovery of a breach. A breach occurs if unsecured PHI is acquired, used or disclosed in a manner that is impermissible under the Privacy Rules, unless there is a low probability that the PHI has been compromised.

Right to a Paper Copy of This Notice

The Covered Person has the right to a paper copy of this Notice, even if he/she has agreed to accept this Notice electronically.

COMPLAINTS

A Covered Person may complain to the Plan if he/she believes that the Plan has violated these privacy rights. The Covered Person may file a complaint with the Plan by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. A copy of a complaint form is available from this contact office.

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

The Plan will not penalize or in any other way retaliate against a Covered Person for filing a complaint with the Secretary or with the Plan.

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "SECURITY STANDARDS")

1. DEFINITIONS

a. The term "Electronic Protected Health Information" ("EPHI") has the meaning set forth in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and generally means individually identifiable health information that is transmitted or maintained in any electronic media.

b. The term "Security Incidents" has the meaning set forth in Section 164.304 of the Security Standards (45 C.F.R. 164.304) and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

2. PLAN SPONSOR OBLIGATIONS

Where EPHI 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 EPHI as follows:

a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

b. Plan Sponsor shall ensure that the adequate separation that is required by Section 164.504 (f) (2) (iii) of the Security Standards (45 C.F.R. 164.504 (f) (2) (iii)) is supported by reasonable and appropriate security measures;

c. Plan Sponsor shall ensure that any agents, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect such EPHI; and

d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

i.) Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware of any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's EPHI; and

ii.) 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.

e. Plan Sponsor shall make its internal practices, books, and records relating to its compliance with the Security Standards to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with the Security Standards.

DECLARATION OF DOMESTIC PARTNERSHIP

I. Declaration:

We, _____ and _____
(Employee Name -Print Name) ***(Domestic Partner -Print Name)***
each certify and declare that we are domestic partners in accordance with the following criteria:

II. Status:

1. We affirm that this domestic partnership began on or about _____/_____/_____.

2. We are each other's sole domestic partner, and we intend to remain so indefinitely.

3. Neither of us is married to or legally separated from anyone else nor has had another domestic partner within the prior six (6) months.

4. We are both at least eighteen (18) years of age and mentally competent to consent to contract.

5. We are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which we legally reside.

6. We cohabit and reside together in the same residence and intend to do so indefinitely. On the date we are making this Declaration, we have resided in the same household for at least twelve (12) months.

7. We are engaged in a committed relationship of mutual caring and support and are jointly responsible for our common welfare and living expenses. Our interdependence can be demonstrated by providing written documentation of at least three of the following (please check appropriate items and attach copies of appropriate documentation):

_____ Common ownership of real property (joint deed or mortgage agreement) or a Common leasehold interest in property (e.g., rental agreement).
_____ Common ownership of a motor vehicle.
_____ Driver's license listing a common address.
_____ Proof of joint bank accounts or credit accounts.
_____ Proof of designation as the primary beneficiary for life insurance or retirement Benefits, or primary beneficiary designation under a partner's will.
_____ Assignment of a durable Property Power of Attorney or Healthcare Power of Attorney.

9. We are not in this relationship solely for the purpose of insurance coverage.

III. Dependent Children of Domestic Partner

We understand that dependent children of _____ (Domestic Partner -Print Name) are eligible for coverage when they are all of the following:

1. Unmarried;

2. Primarily dependent on the employee or domestic partner for support;

3. Living with the employee and domestic partner in a regular parent-child relationship;

4. The age/school requirements of any plan for benefits; and

5. May be claimed by the employee or domestic partner as a dependent as defined III IRC Section 152. We understand that evidence of parental status and common residency must be submitted to the Administrator consistent with the requirements of the plan of benefits.

IV. Change in Domestic Partnership:

1. We understand that we have an obligation to notify the Administrator by filing a Declaration of Termination of Domestic Partnership if there is any change in our domestic partnership status as attested to in this Declaration that would terminate this Declaration (e.g., due to death of a partner, a change in residence of one partner, termination of the relationship, etc.). We will notify the Administrator by filing the appropriate Declaration within thirty-one (31) days of such change.

2. We understand that, regardless of whether a Termination of Domestic Partnership form is filed, coverage for the domestic partner or dependent(s) of the domestic partner will end at the earliest of the following:

(a) The termination of the employee's employment, or for the purpose of healthcare coverage, the employee's eligibility for benefits coverage for any other reason;
(b) The death of the employee;
(c) The death of the Domestic Partner;
(d) Either the employee or Domestic Partner no longer meets the eligibility requirements of domestic partnership as defined in this Declaration; or
(e) The filing of the Termination of Domestic Partnership form with the Administrator.

V. Acknowledgements:

1. We understand that this Declaration must be filed in order for a Domestic Partner (and eligible dependents) to be eligible for coverage under the applicable insurance plans and that filing this Declaration does not enroll us for any benefits. We understand that this Declaration of Domestic Partnership must be filed within 31 days of the Domestic Partner or dependent becoming eligible in order to be treated as a "change in status."

2. We understand that in addition to filing this Declaration, the employee must complete the necessary benefit enrollment forms, also within 31 days for any healthcare plans in which the employee is enrolling his/her Domestic Partner or eligible children of his/her Domestic Partner for healthcare benefits. Eligible Domestic Partners (and their dependents) also may be enrolled in the Administrator's healthcare plans at the annual reenrollment period or following a life event, provided they meet all eligibility requirements at the time they enroll.

3. We acknowledge that filing this Declaration does not automatically result in the naming of the Domestic Partner as beneficiary for any Administrator benefit plan. The employee must complete the appropriate beneficiary designation procedures for each respective plan in order for the Domestic Partner (or any other named beneficiary) to receive survivor benefits for the Administrator Plans including the Profit Sharing and Retirement Plan, and Life and AD&D insurances. These programs require separate forms.

4. We understand that, unless the Domestic Partner and his/her children qualify as dependents of the Employee for tax purposes in accordance with IRS rules: (1) the amount of any Administrator contribution to the cost of coverage for the Domestic Partner and his/her eligible children constitutes taxable income to the employee, which income is imputed and added to the employee's paycheck each pay period; (2) medical expenses of the Domestic Partner and his/her eligible children are not reimbursable under the terms of the Member Library's flexible spending account plan; and (3) any additional premium or contribution required to be paid by the employee to provide coverage to the Domestic Partner and his/her eligible children cannot be paid on a pretax basis. The additional premium is deducted from the employee's paycheck on an after tax basis each pay period.

5. We acknowledge that continuation of health care coverage under COBRA is not offered to Domestic Partners or children of Domestic Partners upon termination of their coverage for any reason.

6. We have provided the information in this Declaration for use by the Administrator for the sole purpose of determining our eligibility for certain Domestic Partner benefits. We understand and agree that the Administrator is not legally required to extend any such benefits and that the Administrator has the right, at its discretion, to discontinue providing any coverage that is offered, or may be offered in the future, to Domestic Partners and dependents of Domestic Partners.

7. We understand that a civil action may be brought against one or both of us for any losses (as well as attorneys' fees and costs) due to any false statement contained in this Declaration or for

failure to notify the Administrator of changed circumstances as required in Section IV above. I, the undersigned employee, further understand that falsification of information in this Declaration, or failure to notify the Administrator of changed circumstances pursuant to Section IV above, may lead to disciplinary action against me, including discharge from employment.

8. We understand that this Declaration may have legal implications relating, for example, to our ownership or property or to taxability of benefits provided, and that before signing this Declaration, we should seek competent legal advice concerning such matters.

9. Each of us understands that all group health and other insurance coverages for Domestic Partners are governed by the terms of the underlying plans, which are subject to change at any time, in the sole discretion of the Administrator. We also understand that in the event of a conflict between any information set forth by the Administrator in this document and the official plan documents, the official documents shall govern in all cases.
This Declaration is a record of the Administrator and, therefore, is subject to Administrator policy, practice, and periodic audits.

We affirm, under penalty of perjury, that the statements in this Declaration are true and correct.

_____	_____	_____/_____/____	_____/____/____
Employee's Signature	***Employee SSN***	***Date of Birth***	***Today's Date***
_____	_____	_____/_____/____	_____/____/____
Domestic Partner's Signature	***Domestic Partner's SSN***	***Date of Birth***	***Today's Date***

_____
Address

_____	_____	_____
City	***State***	***Zip***

Sworn to before this _____

Day of _____, _____

_____
Notary Public (affix seal)

DECLARATION OF TERMINATION OF DOMESTIC PARTNERSHIP

I, _____, certify and declare that:
(Employee -Print Name)

_____ and I are no longer domestic partners as of
(Domestic Partner -Print Name)

_____/_____/_____ (date). I understand that coverage for this individual and his/her dependent children will terminate on the date set forth herein.

The Declaration of Domestic Partner attested to and filed by me with the Administrator shall be and is terminated as of this date; and The termination of the Declaration of Domestic Partnership is a result of either termination of the partnership or death of the Domestic Partner; and I understand that another Declaration of Domestic Partnership cannot be filed until twelve months from the date the relationship ends (as indicated above); and In the event that termination of this relationship is not due to the death of my Domestic Partner, I have mailed a copy of this notice to my former Domestic Partner at:

_____

_____

_____
(former Domestic Partner's address)

_____
I affirm, under penalty and perjury, that the above statements are true and correct.

_____ _____
Employee's Signature ***Date***