PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

FOR

DELAWARE COUNTY GOVERNMENT

EMPLOYEE BENEFIT PLAN

AMENDED AND RESTATED AS OF

AUGUST 1, 2010

Unified
Group Services

IMPORTANT PLAN INFORMATION

Plan Name	Delaware County Government Employee Benefit Plan
Plan Number	501
Plan Year	The Plan Year is the twelve- (12) month period beginning on August 1st and ending on July 31st of each year.
Restatement Effective Date	August 1, 2010
Employer Name and Address	Delaware County Government 100 W Main Street, Room 208 Muncie, IN 47305 765-741-3397
Employer Tax ID Number	35-6000140
Plan Administrator	Delaware County Government
Plan Fiduciary	same as Plan Administrator
Plan Supervisor	Unified Group Services, Inc. P.O. Box 10 Pendleton, IN 46064 (800) 291-5837 Unified Group Services, Inc., as the Plan Supervisor does not insure or guarantee the payment of any Plan benefits.
Utilization Review Company	Hines and Associates
Type of Plan and Administration	The Plan is a self-funded employee welfare plan that provides health benefits for Eligible Employees and their Dependents. A third party administrator (the Plan Supervisor) provides the administration.
Role of Insurance Company	Stop-loss insurance has been obtained for indemnification against major losses from the self-funded nature of the Plan. However, benefits under the Plan in no way shall be guaranteed by any such insurance, and the issuer of any such insurance does not provide any administrative services to the Plan. Covered Persons have no right to or legal interest in the proceeds of any such insurance.

Certain information is required by law to be specifically provided to Plan participants. To help you find this information, listed below is each type of information and where you can find it in the rest of this Summary Plan Description.

PLEASE NOTE: Pre-admission certification is required for all Inpatient admissions and surgeries, Outpatient surgeries (other than in physician's office), Outpatient MRIs, CT Scans, and PET Scans. Further, it is recommended to certify in advance any First Trimester Maternity and Outpatient chemotherapy and radiation therapy. The pre-admission certification is designed to confirm Medical Necessity; appropriateness of requested length of stay and appropriateness of proposed location of care.
See page 38 for important details.
The Plan also uses case management to limit costs.

Eligibility	The Plan's requirements respecting eligibility for participation and for benefits are set forth in the Section *Eligibility, Enrollment and Termination of Coverage*.

QMCSO	Participants and beneficiaries in the Plan can obtain, without charge, a copy of procedures governing qualified medical child support order (QMCSO) determinations from the Plan Supervisor.
Description of Benefits	A description of benefits under the Plan is set forth in the Sections *Benefit and Information Grid, Medical Benefits, Covered Services, Services Not Covered, Organ and Tissue Transplants, Prescription Drug Benefits and Dental Benefits.*
Preventive Services	The extent to which preventive services are covered under this Plan is described in Sections *Benefit and Information Grid, Covered Services, Services Not Covered, Prescription Drug Benefits and Dental Benefits*
Specific Medical Benefits	Provisions regarding whether, and under what circumstances, coverage is provided under the Plan for medical tests, devices, and procedures are set forth in Sections *Benefit and Information Grid, Covered Services, Services Not Covered, Organ and Tissue Transplants, and Dental Benefits.*
PPO Network	Provisions governing the use of network providers, which providers are in network, and whether and under what circumstances coverage is provided under the Plan for out-of-network services are set forth in Sections *PPO Network Benefits* and *Benefit and Information Grid.* A detailed list of network providers will be made available upon request, without charge, as a separate document.
Prescription Drug Benefits	Provisions regarding whether, and under what circumstances, existing and new drugs are covered under this Plan are set forth in Sections *Benefit and Information Grid, Covered Services, Services Not Covered, Organ and Tissue Transplants, Prescription Drug Benefits and Dental Benefits.*
Childbirth Benefits	Employee Benefit Plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable). This Plan's coverage of childbirth is described in the Section *Covered Services.*
Emergency Care	Conditions or limits applicable to obtaining emergency medical care are set forth in Sections *Benefit and Information Grid, Covered Services, Services Not Covered and Dental Benefits.*
Caps/Maximums	Annual and lifetime caps or maximums and other limits on benefits under the Plan are set forth in the Sections *Benefit and Information Grid, Medical Benefits, Covered Services, Services Not Covered, Organ and Tissue Transplants, Prescription Drug Benefits and Dental Benefits.*
Cost of Plan Benefits	Provisions regarding premiums, Deductibles, Coinsurance, and Copayment amounts for which the Covered Person will be responsible are set forth in the Sections *Medical Benefits Benefit and Information Grid,* and *Funding.*
Loss of Benefits	Circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of any benefits that a Covered Person might otherwise reasonably expect the Plan to provide are described in Sections *Eligibility, Enrollment, and Termination of Coverage.*
Continuation Coverage	The rights and obligations of Covered Persons with respect to continuation coverage are set forth in Section *Eligibility, Enrollment and Termination of Coverage* and *Continuation of Coverage.*

Claim Procedures	Procedures governing claims for benefits, applicable time limits, and remedies available to resolve claims that are denied in whole or in part are set forth in Section *Case Management, Cost Containment for Hospital & Surgical Services*, and *Administration of the Plan.*
Termination/ Amendment of Plan	Provisions governing the authority of the Employer or others to terminate the Plan or amend or eliminate benefits under the Plan and the circumstances under which the Plan may be terminated or benefits may be amended or eliminated are set forth in Sections *Entry and Withdrawal of Employers* and *Amendment and Termination of Plan.* Provisions governing the benefits, rights, and obligations of participants and beneficiaries under the Plan upon termination of the Plan or amendment or elimination of benefits under the Plan are set forth in Section *Amendment and Termination of Plan.* If the Plan is amended in any material respect or terminated, you will be notified in writing.

Unified Group Services

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PREAMBLE

Delaware County Government (the "Company") provides several fringe benefits to its Eligible Employees. These benefits include health, prescription drug and dental.

As of the Effective Date, the Company hereby establishes the Delaware County Government Employee Benefit Plan (the "Plan") for the benefit of Covered Persons (as defined below). This Plan is a continuation of several welfare benefit arrangements maintained by the Company. The Company hereby amends and restates the Plan as of August 1, 2010. This Plan is not in lieu of and does not affect any requirements for coverage under Worker's Compensation laws of any state.

ELIGIBILITY, ENROLLMENT, AND TERMINATION OF COVERAGE

Each Eligible Employee or Dependent shall become covered under this Plan in accordance with the following rules:

Eligible Employees. An employee of the Employer is eligible for coverage under this Plan if he or she is considered fulltime per the salary ordinance of Delaware County Government.

For elected officials, political appointees and chief deputies coverage begins the first day of Employment with Delaware County Government. Coverage for all other Employees begins the first day immediately following the completion of sixty (60) days of employment with the Company. Completion of an enrollment form is also a Plan requirement.

Dependents. A family member of an Eligible Employee will become eligible for coverage under this Plan as a Dependent on the first day that the Eligible Employee is eligible for coverage under this Plan and the family member satisfies the following requirements:

(1) Spouse. An individual is eligible for coverage under this Plan as a Dependent if he or she is legally recognized as the marital partner of a Covered Eligible Employee. The Plan Administrator may require documentation proving a legal marital relationship for verification of eligibility at any time.

(2) Child. An individual is initially eligible for coverage under this Plan as a Dependent if he or she is a child (biological child, adopted child, child placed for adoption or if the Eligible Employee provides more than 50% of his or her care, a step-child, child under legal guardianship, grandchild, or other blood relative) of an Eligible Employee. A child of an Eligible Employee remains eligible as a Dependent until the end of the Calendar Year in which he or she attains age twenty-four (24).

This age limit does not apply to an unmarried child who has a mental or physical disability and depends on the Eligible Employee for support as long as the debilitating condition existed before coverage otherwise would have ended. For a Dependent child with a disability, the Plan Administrator must be furnished with proof satisfactory to it as to the Dependent child's disability within one hundred twenty (120) days after the later of the date the Dependent child is first eligible for coverage under this Plan or the date the Dependent child reaches the otherwise disqualifying age, and as may be requested by the Plan Administrator from time to time.

Child Support Order. A child may become eligible for coverage as a Dependent under this Plan as set forth in a qualified medical child support order. The Plan Administrator will establish written procedures for determining (and shall have sole discretion to determine) whether a medical child support order is qualified under Section 609 of ERISA and for administering the provision of benefits under the Plan pursuant to a qualified medical child support order. The Plan Administrator may seek clarification and modification of the order, up to and including the right to seek a hearing before the court or agency which issued the order.

(3) Exceptions. The following individuals are excluded as eligible for Dependent coverage: an individual who lives in the Covered Eligible Employee's home but who is not eligible as previously described; the legally separated or divorced former spouse of the Eligible Employee; any person who is on active duty in any military service of any country; or any person who is eligible for coverage under the Plan as an Eligible Employee.

Multiple Family Members Eligibility. An individual cannot be covered as both an Eligible Employee and a Dependent under the Plan or a Dependent of more than one Eligible Employee. The following rules govern the coordination of the eligibility rules for multiple family member Eligible Employees:

(1) Married Eligible Employees

(a) If both married Eligible Employees are eligible for coverage under the Plan, the Eligible Employees may choose which Eligible Employee shall be deemed the Employee for purposes of Plan eligibility. The covered Eligible Employee's spouse and any eligible children would then be deemed eligible Dependents.

(b) In the event of a dispute, the Eligible Employee who has been in the Plan the longest assumes status as the covered Eligible Employee under the Plan.

(c) If the coverage is terminated, COBRA (as defined in Section *Continuation of Coverage)* will not be offered to the extent coverage is available through the spouse by means of the spouse's employment at the Company. The spouse would automatically assume status as the covered Eligible Employee, and the individual whose coverage was terminated will become an eligible dependent under the Plan.

(2) Employment of a Dependent. When a child of a covered Eligible Employee becomes eligible for coverage as an Eligible Employee, he or she will become covered as an Eligible Employee under this Plan rather than as a Dependent.

Automatic Enrollment. An Eligible Employee or Dependent who was covered under one of the several welfare benefit arrangements in existence as of the day preceding this Plan's Effective Date remains covered under this Plan as of the Effective Date without the need for separate enrollment in this Plan.

Regular Enrollment. An individual who is not automatically enrolled in the Plan as described above may enroll in the Plan within thirty-one (31) days of the date he or she first becomes eligible for coverage. Submission of a completed and signed enrollment form is also required.

Special Enrollment. If an Eligible Employee or Dependent declined coverage hereunder at the time of initial eligibility (and, if required, stated in writing at that time that coverage was declined because of alternative health coverage) but subsequently loses coverage under the other health plan and applies for coverage under this Plan within thirty-one (31) days of the loss, such individual shall be a Special Enrollee provided such person: (1) was under a COBRA continuation provision and the coverage was exhausted; or (2) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated. Individuals who lose other coverage due to non-payment of premiums or for cause (e.g., filing fraudulent claims) may not be Special Enrollees hereunder.

An Eligible Employee or Dependent who seeks to enroll in the Plan as a result of the acquisition of a Dependent through marriage, birth, adoption, or placement of adoption shall be a Special Enrollee hereunder if enrolled within thirty-one (31) days of the acquisition of the Dependent. Coverage for a newborn or newly adopted Special Enrollee becomes effective as of the date of the adoption, birth, or placement for adoption. Coverage for a Special Enrollee other than a newborn or newly adopted child becomes effective concurrent with the qualifying event.

An Eligible Employee (and an eligible Dependent) shall also be permitted to enroll in this Plan if (i) the Eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of the Social Security Act and coverage of the Eligible Employee or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage; or (ii) the Eligible Employee or Dependent becomes eligible for assistance with respect to coverage under the Plan under a Medicaid plan or State child health plan. An Eligible Employee or Dependent shall be entitled to enroll in this Plan under the preceding sentence only if the Eligible Employee requests coverages under this Plan not later than sixty days after the date the Eligible Employee's or Dependent's coverage under Medicaid or a State child health plan terminates or within sixty days after the date the Eligible Employee or Dependent is determined to be eligible for assistance under Medicaid or a State child health plan.

Note: Newborns are eligible for Special Enrollment in this Plan, however if the maternity charges for the mother are not covered under this Plan, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

Late Enrollment. Notwithstanding anything in the above Subsections to the contrary, if an Eligible Employee or Dependent completes and returns the required enrollment form (and agrees to make the required contribution) more than thirty-one (31) days after the date on which he or she otherwise satisfies all other requirements for regular or special enrollment for coverage under the Plan, he or she shall be considered a Late Enrollee. Late Enrollees may enroll for coverage under the Plan during the next Open Enrollment Period.

Open Enrollment Period. Late enrollees may enroll for coverage under the Plan during the annual Open Enrollment Period held each year during the month of July with an August 1st effective date of coverage.

Re-Enrollment after Termination of Coverage. In the event an Eligible Employee is covered under the Plan, voluntarily chooses to terminate such coverage (for himself or herself or for a covered Dependent), does not terminate employment with the Company, and thereafter desires to be covered (or to have a previously-covered Dependent covered) again under the Plan, the Employee or Dependent may do so only as a Late Enrollee or Special Enrollee as described above.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and Enrollment requirements unless coming on the plan directly from COBRA coverage sponsored by the Employer.

Coverage during Layoff. Upon layoff Covered Persons may exercise their rights under the COBRA Continuation of Coverage provisions of this Plan. If recalled to work the waiting period will not apply. The Pre-existing Condition Limitation provision of the Plan will apply only to the extent it was in effect on the last day of the previous coverage under this Plan, reduced by any creditable coverage if any.

Part-Time to Full-Time Employees. Part-time employees who become full time must satisfy the waiting period as a fulltime employee.

Continuation During Periods of Employer-Certified Disability or Leave of Absence. An Eligible Employee may remain eligible for a limited time if full-time work ceases due to disability or leave of absence provided he/she pays any required contribution. This continuance will end as follows:

(a) the date this Plan terminates;
(b) the end of the month of termination of employment;
(c) upon eligibility for coverage in any other Employee Benefit Plan that does not limit coverage for the disabling condition;
(e) the date the Eligible Employee is no longer considered Disabled;
(f) the date the leave of absence ends;
(f) the end of the ninety day period immediately following the last day of active work (time runs consecutive to FMLA, if applicable).

Continuation of Coverage of Disabled Public Safety Employees. A Public Safety Employee (fire fighter, sheriff, county police officer or municipal police officer) may continue coverage for him/herself and his/her Spouse and Child(ren) in the event of disability. The disabled Employee must be receiving disability benefits under Indiana Code Section IC 36-8-6, IC 36-8-7, IC 36-8-7.5, IC 36-8-8, or IC 36-8-10.

The disabled Employee must make a written request for the continuation of coverage to the Employer within 90 days after his/her disability begins and the Employer may require that the disabled Employee pay for all or a portion of the cost of the coverage. Coverage shall terminate herein upon the earlier of:

(a) The end of the month the disabled Employee becomes eligible for Medicare (unless due to End Stage Renal Disease), or;

(b) The date the Employer ceases to maintain the Plan.

Continuation of Coverage for Surviors of Public Safety Employees. A surviving Spouse or Child of a Public Safety Employee who dies in the line of duty may continue coverage under the plan provided he/she makes a written request for coverage within ninety (90) days after the death of the Public Safety Employee and pay the amount the Employee would have had to pay for coverage. Coverage terminates upon the earlier of:

(a) The end of the month the Survivor becomes eligible for Medicare (unless due to End Stage Renal Disease)

(b) The date the Employer ceases to maintain the Plan.

(c) The end of the month the Spouse remarries.

(d) The end of the month the Spouse becomes eligible for coverage through his/her employment.

Continuation of Coverage for Retirees. Retired Employees may continue coverage for themselves, and their eligible Spouse and Children that were covered under the plan on the date immediately proceeding the date of the employees retirement. To be eligible for this retiree coverage, on the date immediately prior to his/her retirement, the Employees age plus years of service must equal at least seventy (70) years, with a minimum of ten (10) of those years being continuous years of service with Delaware County Government immediately proceeding the date of retirement.

Further a retiree who is eligible for coverage under the Plan under a prior ordinance of Delaware County Government will be able to continue retirement benefits pursuant to such ordinance.

The Retiree must make a written request for the continuation of coverage to the Employer within 90 days of the date of retirement with Delaware County Government. The Employer may require that the Retiree pay for all or a portion of the cost of the coverage.

If an eligible retiree seeks employment elsewhere and participates in that employer's health insurance, that coverage shall be primary and Delaware County Government coverage is secondary.

Spouses and Dependents not enrolled in the Plan on the date immediately proceeding the employees date of retirement are not eligible to enroll in the Plan. Further, if an eligible retiree declines or cancels his/her retiree coverage with Delaware County Government, he/she can not reenroll at a later date.

Retirees may remain eligible under this Plan as long as the coverage remains a part of the County's group plan of insurance.

In the event of death of the Retiree, if the covered Dependents pay the amount the Retiree would have been required to pay, such Dependents may continue coverage under the Plan. The Retiree Dependents coverage shall terminate upon the earliest of the following:

(a) The date the Employer ceases to maintain the Plan; or

(d) The end of the month of the surviving spouse's remarriage; or

(c) With regard to any Dependent of the retiree, the end of the month a surviving Spouse or Child(ren) becomes covered for health insurance through employment; or

(d) With regard to a Child of the retiree, the end of the month a surviving Child becomes ineligible under the guidelines of this plan.

Military Leave. Notwithstanding anything in this Plan to the contrary, with respect to any Eligible Employee or Dependent who loses coverage under this Plan during the Eligible Employee's absence from employment by reason of military service, any applicable Waiting Period and Pre-Existing Condition limitation described herein shall not be imposed upon the reinstatement of such Eligible Employee's or Dependent's coverage upon reemployment of the Eligible Employee unless such Waiting Period or Pre-Existing Condition limitation would apply to such Eligible Employee or Dependent had the Eligible Employee or Dependent not been on military leave of absence.

Termination of Coverage. Except as described in the Section *Continuation of Coverage* and elsewhere in this Section *Eligibility, Enrollment and Termination of Coverage*, the coverage of any Covered Person under the Plan shall terminate on the earliest of the following dates.

(1) The date this Plan is terminated;
(2) With respect to an Eligible Employee, the end of the month he or she ceases to be classified in an Eligible Class of Eligible Employees, whether by a change in job classification, a change in the definition of Eligible Employee, or some other modification of the Plan.
(3) With respect to an Eligible Employee, the end of the month of the Eligible Employee's Employment Termination Date or, if later (such as written severance agreement continuation), the date on which the Eligible Employee's coverage ceases as a result of termination of employment with an Employer;
(4) With respect to a Dependent, the end of the month that he or she ceases to be a Dependent, whether by a change in status, a change in the definition of Dependent, or some other modification of the Plan;
(5) With respect to a Dependent child, the date the related Eligible Employee's coverage terminates;
(6) With respect to a Dependent spouse, the date the coverage of the related Eligible Employee terminates;
(7) With respect to any Covered Person, the date that he or she becomes a full-time member of the Armed Forces of any country; or
(8) With respect to any Covered Person, the date that he or she fails to pay the required contribution, if any, to the Plan.

Change in Status. Each Eligible Employee must notify the Company of any change of address, entrance or the entrance of a Dependent into the military, loss or acquisition of a Dependent, a child ceasing to be a Dependent under the terms of the Plan,

the Eligible Employee's or a Dependent's eligibility for or entitlement to Medicare, or any other change in status which might affect coverage for the Eligible Employee and/or the Eligible Employee's Dependents under the Plan. Notice must be given within thirty (30) days of the change in status, or as soon as reasonably possible whenever a change in such status occurs, except as otherwise required under Section *Continuation of Coverage.* However, the failure to provide notice to the Plan Administrator shall not permit the Eligible Employee and/or Dependent to continue coverage if otherwise ineligible.

Family and Medical Leave Act (FMLA). An Eligible Employee who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this Plan pursuant to FMLA.

During this leave, the Employer will continue to pay the same portion of the Eligible Employee's contribution for the Plan. The Eligible Employee shall be responsible to continue payment for Eligible Dependent's coverage and any remaining Employee contributions. If the covered Eligible Employee fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

If coverage under the Plan was terminated during an approved FMLA leave, and the Eligible Employee returns to work immediately upon completion of that leave, Plan coverage will be reinstated on the date the Eligible Employee returns to work as if coverage had not terminated, provided the Eligible Employee makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to work.

PPO Requirements. Subject to this Section's provisions, an Eligible Employee's eligibility under a PPO Option shall be governed by the applicable contract entered into by the Company and the applicable preferred provider organization.

MEDICAL BENEFITS

General. Subject to the provisions and limitations of the Plan, a Covered Person shall be reimbursed for Covered Charges (other than a Copayment, Deductible or Coinsurance amount for which the Covered Person is financially responsible) resulting from an Injury or Illness Incurred by that Covered Person; provided, however, that no Covered Charges shall be reimbursed, nor other medical benefits paid, with respect to a Covered Person to the extent such Covered Charges, when added to Covered Charges previously reimbursed to that Covered Person, exceed the Maximum Lifetime Limit as set forth in this Section.

Excess Charges. Neither the Plan Administrator nor the applicable Plan Supervisor shall be liable for the payment of any benefit in excess of the Usual & Customary Charge. If requested by a Covered Person, the applicable Plan Supervisor shall review its initial determination with respect to a Usual & Customary Charge under this Plan and may attempt to reach an agreement with the applicable service provider in order to compromise, settle or otherwise reduce the charges incurred by the Covered Person; provided, however, that the Covered Person shall remain financially responsible with respect to such charges incurred and for all other matters that may exist between the Covered Person and the service provider.

Offset of Benefits. If any payment is erroneously made (either with respect to the amount, identity of the payee or the fact of payment) under this Plan, this Plan may recover that erroneous payment, whether it was made as the result of the Plan Administrator's or applicable Plan Supervisor's own error, from the person to whom it was made or from any other appropriate party. If any such erroneous payment is made directly to a Covered Person, this Plan may offset future payments made directly to that Covered Person by the amount of such erroneous payment.

Request for Additional Claim Information. The Plan Supervisor may need to request additional information from the Covered Person before a claim for benefits can be adjudicated. A request for additional information may occur:

1. when necessary information is missing from the claim (i.e. birth date, date of service, diagnosis etc.);
2. when coordination of benefits information is needed;
3. (if applicable) when a pre-existing condition determination is in progress; or
4. when the claim appears to be related to an accident (see Section *Subrogation Rights*).

The Plan Supervisor will send written correspondence (letter or Explanation of Benefits (EOB)) to the Covered Person and the provider of services (if applicable) detailing the information needed. If related claims are received, an Explanation of Benefits (EOB) will again be sent to the Covered Person and Provider (if applicable) explaining the claim (s) in question will be closed until the requested information is received from the Covered Person. When the claim information is received, the Plan Supervisor will reopen and adjudicate the claim (s) by the terms as set forth in this Plan.

Pre-Existing Condition Limitation. Covered Charges Incurred for a Pre-Existing Condition (as described in the Section *Definitions*) of a Covered Person are not payable under this Plan if Incurred during the twelve (12) month period after the Covered Person's Enrollment Date if the Covered Person is a Regular, Special or Late Enrollee. However, a Covered Person otherwise subject to the Pre-Existing Condition limitation as described shall have the applicable twelve (12) month period reduced for his or her past Creditable Coverage, if any. The Pre-Existing Condition limitation shall not apply at all to the condition of pregnancy or to a newborn or newly adopted child who becomes covered under the Plan as of the date of birth, adoption or placement for adoption.

Copayments. Covered Persons must pay a Copayment per occurrence of certain Preferred Provider services as outlined in the *Benefit and Information Grid.* Copayments do not accrue towards the Out-of-Pocket Maximum.

Deductibles and Coinsurance. All Covered Charges are subject to Usual & Customary allowances. All charges applied to a Deductible are not applied toward the 100% maximum out-of pocket payment.

Calendar Year Deductible. Covered Persons must pay an annual Deductible as outlined in the *Benefit and Information Grid* prior to Coinsurance payment for all benefits received from non-network providers or any benefits where it is specifically stated in the Plan that Deductible is applicable.

Deductible Three-Month Carryover. Covered expenses incurred in, and applied toward the Deductible in October, November, and December will be applied toward the Deductible in the next Calendar Year. However Deductibles satisfied because of a Family Deductible shall not apply to this Deductible carryover.

Calendar Year Maximum Out-Of-Pocket Limits. Covered Persons must pay an annual Out-Of-Pocket Maximum as outlined in the *Benefit and Information Grid* for any non-network benefits or for benefits specifically stating a Coinsurance limit is applicable.

Maximum Lifetime Limit. There is a Maximum Lifetime Limit of $5,000,000 for all Injuries and Illnesses for each Covered Person under any and all available options of this Plan and any other group health plan maintained by the Employer under which the Covered Person had coverage. This means that no Covered Person will ever receive more than $5,000,000 in benefits from all health plans maintained by the Employer combined.

Secondary Payor Rules. When this Plan is secondary, the Plan will calculate the amount it would have paid had the plan been primary. This will be the "Benefit Maximum". After the primary carrier pays, the remaining eligible expenses will be paid up to 100% not to exceed the benefit maximum. If the expenses which remain after the primary carrier has paid exceed the benefit maximum, the plan will only pay up to the benefit maximum (that the plan would ordinarily have paid if it were primary).

Charges Never Paid at 100%. The charges for the following do not apply to the 100% benefit limit and are never paid at 100%.

1. Deductible(s)
2. Precertification penalties
3. Copayment (s)

PPO NETWORK BENEFITS

Definitions. For purposes of this Section, the terms listed here shall have the following meanings:

Ancillary charges - Charges for additional services related to treatment that are not included in facility charges. Examples of ancillary charges include a radiologist or pathologist services and anesthesiology services.

Annual out-of-pocket maximum - The maximum yearly amount of Covered Charges (excluding Deductibles, Copayments, Cost Containment Penalties, over Usual & Customary Amounts, and non-covered services) that a Covered Person will pay through Coinsurance. Once this maximum is met, the Plan will pay 100% of Covered Charges for the remainder of the year.

Copayment - An amount of money that is paid each time a particular service is used.

Elective treatment – A treatment or procedure not requiring immediate attention and therefore planned for the patient's convenience.

Emergency – Any urgent condition perceived by the patient as requiring immediate medical evaluation or treatment.

In-Network - Services provided by Physicians or Hospitals that are members of the PPO Network.

Out-of-Network - Services provided by Physicians or Hospitals that are not affiliated with the PPO Network.

Precertification - An administrative procedure whereby a provider explains via telephone a treatment plan to a third party for review before the treatment plan is initiated.

Preferred Provider Organization (PPO Network) - A group or network of Physicians and Hospitals (providers) that contract with employer to provide comprehensive medical service. Provider's exchange discounted service for increased volume. A Covered Person's out-of-pocket costs are usually lower than they would be under a traditional, fee-for-service plan.

Eligibility. Eligibility for the Plan is outlined in Section *Eligibility, Enrollment, and Termination of Coverage* and applies to Covered Persons at all Company locations.

Other Network-Related Plan Provisions

Dependents and Eligible Employees who reside outside (fifty (50) miles) the Network Area. Any Covered Dependent or Eligible Employees residing outside the Network area will receive the In-Network level of benefits.

Procedure for seeking Elective treatment outside the PPO Network area. A Covered Person who seeks Elective medical assistance while traveling outside the Network may see any physician. Out-of-Network percentages will apply.

Procedure for seeking Emergency treatment outside the PPO Network area. A Covered Person who requires emergency medical assistance or after-hours care when traveling outside the Network area may obtain the necessary care. Emergency care outside of the PPO Network area will be payable at the In-network level.

Referrals to Specialists. If a Network Physician refers a Covered Person to a specialist, it is the responsibility of the Covered Person to verify, by consulting the PPO Network directory, that the specialist is a Network participant. If the specialist is not in the Network, benefits will be paid at the lower Out-of-Network rate unless the necessary treatment is unavailable from a Network Provider or Facility.

Ancillary Services. When utilizing a PPO Network provider, the following out-of-network services will be paid at the Encore level: Radiologist or Pathologist services, consultation from an out-of-network provider or ER Physician. Also, if the operating surgeon (inpatient or outpatient) is in the PPO Network and the anesthesiologist is not, the anesthesiologist will be paid at the Encore level. Please Note: If the hospital is Out-of-Network the charges will be

considered Out-of-Network unless due to an Emergency or if the required services are unavailable at an In-Network facility.

Network Unavailable. Required services found to be unavailable in the chosen network will be considered at the Encore level.

Preferred Provider Network (PPO) Change. Effective August 1, 2010, due to a change in PPO Network, this plan will have a grace period of ninety days for Covered Persons already in treatment to seek a provider within the new PPO network. Out of network claims incurred during this period will be considered at the Encore level of benefits. In addition, to provide continuity of care any ongoing treatment that began prior to the Effective Date of the new network will continue to be considered at the Encore level if on a case by case basis the Plan determines such care is medically necessarily more beneficial to the participant or presents cost savings to the Plan. This provision shall apply effective with any change in PPO provider network.

BENEFIT SUMMARY

	In-Network Level	Out-of-Network Level	Apply to Out-of-Pocket Maximum	Precert Required
Calendar Year Deductible	$200 per Person $400 per Family Unit	$400 per Person $800 Per Family Unit	Delaware County Government	
Calendar Year Out-of-Pocket Maximum *(excluding Deductible)*	$550 per Person $1,100 per Family Unit	$1,100 per Person $2,200 per Family Unit		
In-Network and Out-of-Network Deductibles and Out-of-Pocket Amounts are Separate and Do Not Accumulate Together.				
Coinsurance	90% -- Unless Otherwise Noted.	70% -- Unless Otherwise Noted All Out-of-Network Services Limited to Usual and Customary		
Lifetime Plan Maximum	$5,000,000			
PRE-EXISTING CONDITION LIMITATIONS				
Permissible only if the limitation relates to a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the six month period before the plan participation started. The pre-existing condition limitation will no longer apply if the person is covered under the Plan for a period of time equal to twelve (12) consecutive months minus the covered person's period of Creditable Coverage.				
PRE-CERTIFICATION REQUIREMENTS				
Pre-Certification Requirements	**Pre-admission certification is <u>required</u> for all Inpatient admissions and surgeries, Outpatient surgeries (other than in physician's office), Outpatient MRIs, CT Scans, and PET Scans. Further, it is <u>recommended</u> to certify in advance any First Trimester Maternity and Outpatient chemotherapy and radiation therapy.** **CALL 800-944-9401**			
HOSPITAL SERVICES				
Hospital Inpatient Facility Charges	After Deductible, 90% paid by Plan	After Deductible, 70% paid by Plan	**Yes**	**Yes**
Hospital Outpatient Facility Charges	After Deductible, 90% paid by Plan	After Deductible, 70% paid by Plan	**Yes**	**Yes for Outpatient Surgery**
Outpatient Hospital Labs, X-ray, Nuclear Imaging	After Deductible, 90% paid by Plan	After Deductible, 70% paid by Plan	**Yes**	**Yes for Nuclear Imaging**
PHYSICIAN SERVICES				
Inpatient Physician and Physician Other than Office Charges *(including anesthesia)*	After Deductible, 90% paid by Plan	After Deductible, 70% paid by Plan	**Yes**	**Yes for Inpatient**
Physician Office Visit Charges *(includes all services performed in office)*	$20 Copay then 100% paid by Plan. Deductible does not apply.	After Deductible, 70% paid by Plan	**Yes, except copay**	**No, except for Nuclear Imaging**
Allergy Services with No Office Visit Charge *(includes testing, serums and injections)*	100% paid by Plan. Deductible does not apply.	After Deductible, 70% paid by Plan.	**Yes**	**No**

	In-Network Level	Out-of-Network Level	Apply to Out-of-Pocket Maximum	Precert Required
EMERGENCY SERVICES				
Emergency Room Services *(copay waived if admitted)*	$100 Copay then 100% paid by Plan. Deductible does not apply.	$100 Copay then 100% paid by Plan. Deductible does not apply.	**No**	**No**
Urgent Care Facility	$35 Copay then 100% paid by Plan. Deductible does not apply.	$35 Copay then 100% paid by Plan. Deductible does not apply.	**No**	**No**
Ambulance	100% paid by Plan, Deductible does not apply.	100% paid by Plan, Deductible does not apply.	**No**	**No**
PREVENTIVE/WELLNESS CARE				
Well Baby/Well Child Care *(including school enrollment physical exams)*	$20 Copay then 100% paid by Plan. Deductible does not apply.	After Deductible, 70% paid by Plan	**Yes, except copay**	**No**
Immunizations *(that have in effect a recommendation from the Centers of Disease Control with respect to the individual and those required for school)*	$20 Copay then 100% paid by Plan. Deductible does not apply.	After Deductible, 70% paid by Plan	**Yes, except copay**	**No**
Adult Routine Exams, Testing and Screenings *(Including Related Labs and X-Rays)*	$20 Copay then 100% paid by Plan. Deductible does not apply.	After Deductible, 70% paid by Plan	**Yes, except copay**	**No**
Routine and Non Routine Mammogram	$20 Copay then 100% paid by Plan. Deductible does not apply.	After Deductible, 70% paid by Plan	**Yes, except copay**	**No**
Diabetic Self Management Training	$20 Copay then 100% paid by Plan. Deductible does not apply.	After Deductible, 70% paid by Plan	**Yes, except copay**	**No**
OTHER MEDICAL SERVICES				
Maternity Services *(for all Covered Persons)*	After Deductible, 90% paid by Plan.	After Deductible, 70% paid by Plan.	**Yes**	**No**
Medical Supplies/ Durable Medical Equipment/Orthotics/ Prosthetics *(includes certain diabetic and asthmatic supplies when obtained from a non-network pharmacy)*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan.	**Yes**	**No**

	In-Network Level	Out-of-Network Level	Apply to Out-of-Pocket Maximum	Precert Required
Extended Care /Skilled Nursing/Rehabilitation Facility *(limited to 60 days per Calendar Year)*	After Deductible, 90% paid by Plan.	After Deductible, 60% paid by Plan	**Yes**	**Yes**
Hospice Facility Services *(with six month life expectancy)*	100% paid by Plan, Deductible does not apply.	100% paid by Plan, Deductible does not apply.	**Yes**	**No**
Hospice Non Facility Services *(with six month life expectancy)*	100% paid by Plan, Deductible does not apply.	100% paid by Plan, Deductible does not apply.	**Yes**	**No**
Home Healthcare	After Deductible 90% paid by Plan – ***Unlimited visits***	After Deductible 70% paid by Plan – ***Limited to 30 visits per Calendar Year.***	**Yes**	**No**
Physical and Occupational Therapy *(Limited to 60 visits combined per Calendar Year)*	$20 Copay, then 100% paid by Plan. Deductible does not apply.	After Deductible, 70% paid by Plan.	**Yes, except copay**	**No**
Speech Therapy *(limited to 20 visits per Calendar Year)*	$20 Copay, then 100% paid by Plan. Deductible does not apply.	After Deductible, 70% paid by Plan.	**Yes**	**No**
Chiropractic Services *(limited to 12 visits per Calendar Year)*	$20 Copay, then 100% paid by Plan. Deductible does not apply.	After Deductible, 70% paid by Plan.	**Yes**	**No**
Other Therapy Services	**In Physicians Office –** $20 Copay, then 100% paid by Plan. Deductible does not apply. **In Other Facility –** After Deductible, 90% paid by Plan	After Deductible, 70% paid by Plan.	**Yes, except copay**	**No**
Organ and Tissue Transplants *(limited to $1,000,000 Lifetime Maximum)*	100% paid by Plan. Deductible does not apply.	After Deductible, the lesser of 50% of billed Charges or 50% of the maximum allowable amount. See Page 24 for details.	**Yes**	**Yes**
MENTAL HEALTH AND SUBSTANCE ABUSE				
Inpatient Mental Health and Substance Abuse *(Including Partial Hospitalization and Intensive Outpatient)*	After Deductible, 90% paid by Plan	After Deductible, 70% paid by Plan	**Yes**	**Yes**
Outpatient Mental Health and Substance Abuse	$20 Copay, then 100% paid by Plan, Deductible does not apply.	After Deductible, 70% paid by Plan	**Yes, except copay**	**No**

	In-Network Level	Out-of-Network Level	Apply to Out-of-Pocket Maximum	Precert Required
PRESCRIPTION DRUG PROGRAM				
Retail Prescription Drugs *(30 day supply)*	Copays for: Generic $5 Preferred Brand $20 Non Preferred Brand $30	After Deductible, 50% reimbursed by Plan	**No**	**No**
Retail and Mail Order Specialty Drugs *(30 day supply)*	Copays for: Generic $5 Preferred Brand $20 Non Preferred Brand $30	After Deductible, 50% reimbursed by Plan	**No**	**No**
Mail Order Prescription Drugs *(90 day supply)*	Copays for: Generic $10 Preferred Brand $40 Non Preferred Brand $60	After Deductible, 50% reimbursed by Plan	**No**	**No**
Certain diabetic and asthmatic supplies are covered in full with no copayment when obtained from an In-Network pharmacy. These supplies are covered as Medical Supplies or Durable Medical Equipment if obtained from an Out-of-Network Pharmacy.				

DENTAL BENEFITS PLAN	
Calendar Year Deductible	None
Calendar Year Maximum	$1,500 per Covered Person
Lifetime Orthodontia Maximum	$1,000 per Covered Person Does not apply to Calendar Year Maximum Orthodontia services limited to children under age 19
Reimbursement Schedule	Class I - Diagnostic/Preventive 100% paid by Plan Class II -- Basic 80% paid by Plan Class III -- Major 50% paid by Plan Class IV -- Orthodontia 50% paid by Plan

This benefit and information grid is a summary of the plan benefits. For more complete information, please see sections *Covered Services, Prescription Drug Benefits, Dental Benefits,* and *Services Not Covered.*

COVERED SERVICES

Subject to any limitations described elsewhere herein, the Plan shall cover the following services and supplies:

Hospital Services

(1) **Inpatient Hospital** room and board services

(2)

(3) After **23 observation hours**, a confinement will be considered an inpatient confinement.

(3) **Hospital ancillary and professional services including:**

(a) Operating and treatment room and delivery room service;
(b) Anesthesia and administration thereof;
(c) Oxygen and other gas therapy, and its administration;
(d) X-ray and diagnostic laboratory procedures and services;
(e) Medical and surgical supplies;
(f) Drugs and medicines approved by the FDA;
(g) Respiratory/inhalation therapy, speech therapy and physical or occupational therapy;
(h) Pathological and laboratory services;
(i) Electrocardiograms;
(j) Basal metabolism tests;
(k) Pneumoencephalograms;
(l) Blood transfusions, including the cost of blood and blood plasma expander.

(4) Appropriate **Hospital Rooms** required for the treatment of a condition.

(6) **Outpatient Hospital** services.

(7) **Hospital** confinement for dental services if medically necessary due to age, or the mental or physical condition of the covered person.

Hospital Room Limitation - Charges for a Hospital room shall be limited to the semi-private room charge in the Hospital where the Covered Person is confined; provided, however, that, if the Hospital in which the Covered Person is confined does not have semi-private rooms, charges shall be limited to the lowest private room rate in that Hospital; provided, further, that if a private or specialty care room (intensive care, coronary care, etc.) is Medically Necessary, charges for that room shall be covered at the standard rate for that room in the Hospital where the Covered Person is confined.

Specialized Treatment Facilities

(1) Charges made by an **Ambulatory Surgical Facility, Rehabilitation Facility, or Birthing Center** for services and supplies furnished as deemed Medically Necessary.

(2) Charges made by a **Home Health Care Agency** for services and supplies furnished to a covered individual in his home are considered Covered Charges. The attending Physician must provide the diagnosis and furnish a written program of health care and certification that proper treatment of the Illness or Injury would require hospitalization if services and supplies were not otherwise available under a Home Health Care program.

Covered expenses include:

(a) Part-time or intermittent nursing care (up to four (4) hours per visit) by a Registered Nurse or Licensed Practical Nurse;
(b) Part-time or intermittent home health aide services which consist primarily of caring for the individual;
(c) Physical, occupational or speech therapy; and
(d) Medical supplies, drugs, and medicines prescribed by a Physician and laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under this Plan if the individual had remained in the Hospital.

For purposes of this provision, see Section *Definitions*, "Home Health Care" and "Home Health Care Agency".

Home Health Care Agency Limitation - Charges for Home Health Care services and supplies are covered only for care and treatment of an Injury or Illness when Hospital or Skilled Nursing Facility confinement would otherwise be required. A Home Health Care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four (4) hours of Home Health aide services.

(3) **Extended Care Facility and Skilled Nursing Facility.** Covered Charges include Inpatient convalescent home care for the following services and supplies furnished while the patient is in an Extended Care Facility or Skilled Nursing Facility, is under the continuous care of the attending Physician and requires twenty-four (24) hour care:

(a) Room and Board and other services and supplies furnished by the facility for necessary care (other than personal items);
(b) Professional services;
(c) Use of special treatment rooms;
(d) X-ray and laboratory examinations;
(e) Physical, occupational and speech therapy;
(f) Oxygen and other respiratory therapy;

For purposes of this provision, see Section *Definitions*, "Extended Care Facility" and "Skilled Nursing Facility".

Extended Care/Skilled Nursing Facility Limitation - The room and board and nursing care furnished by an Extended Care/Skilled Nursing facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility;
(b) the attending Physician certifies that the confinement is needed for further care of the condition that caused or could cause the Hospital confinement; and
(c) the attending Physician completes a treatment plan, which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Two or more periods of convalescent care facility confinement will be considered one if the later confinement results from causes that are related to those of the previous one and in the meantime the Eligible Employee does not return to the Full-time duties of a regular job for at least two consecutive weeks.

(4) **Hospice care.** For purposes of this provision, see Section *Definitions*, "Hospice". Benefits. Benefits are subject to the maximums and limitations set forth in Section *Benefit and Information Grid.*

(a) Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal and determined that the person is not expected to live more than six (6) months. Benefits are payable subject to limits for all Illness.

(b) Room and board and services and supplies while confined in a Hospice or Hospice setting.

(c) Part-time nursing care by or under the supervision of a registered nurse (RN).

(d) Home health aide services.

(e) Nutrition services and special meals.

Bereavement counseling services are not covered.

Surgical Services

(1) When **more than one surgical procedure** is performed during an operation, 100% of the Usual & Customary Charge for the primary procedure, 50% of the Usual & Customary Charge for second and for any additional incisions and procedure types payable under this Plan. The following situations are exceptions:

(a) Fractures: When reductions (or treatment) of one or more separate and distinct fractures take place, 100% of the Usual & Customary charge of each procedure is allowable.
(b) More than One Surgeon: When the skills of two or more physicians are required and each surgeon performs separate operations, the allowance is 100% of Usual & Customary for each procedure, provided each of the doctors bills separately for the procedure he/she performed. This applies even though both procedures were performed at the same operative session

(2) Charges for a **second and third surgical opinions** which are provided to determine the medical necessity of an elective operation (one that is not of an emergency or life-threatening nature) and which is rendered by a Physician who is neither the operating surgeon nor associated with the Physician who recommended the surgery. Payment is subject to the benefits listed in Section *Benefit and Information Grid.*

(3) Technical assistance by a **Physician** or a **Certified Surgical Assistant (CSA)** in the performance of a **surgical procedure** provided that the surgical procedure necessitates the use of an **assistant.** The assistant's expenses are not to exceed 20% of the primary surgeons charge including any Usual and Customary limitations. **Services of a Physician's Assistant (PA) may be further reduced.**

(4) **Anesthetic services,** when performed by a licensed anesthesiologist or certified registered nurse anesthetist in connection with a surgical procedure.

(5) **Circumcision** for newborns and when Medically Necessary.

(6) Surgical treatment of **Temporomandibular Joint Dysfunction (TMJ)** subject to the limitations set forth in section *Benefit and Information Grid.*

(7) **Outpatient surgery.**

(8) **Orthognathic surgery with Medical Necessity.**

(9) **Podiatry surgery.**

(10) **Sterilization** (for Covered Employees and Spouses) including:

(a) Vasectomy;
(b) Tubal ligation

(11) **Reconstructive surgery** when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part that without correction prevents or significantly hinders functionality, an accidental injury, to correct deformities caused by disease or trauma, hemangiomas and port wine stains of the head and neck areas for children age 18 or younger, or for breast reconstruction following a total or partial mastectomy. **Further, regarding breast reconstruction after a total or partial mastectomy the following are covered expenses:**

(a) reconstruction of the breast on which the mastectomy has been performed;
(b) reconstruction of the other breast to produce symmetrical appearance; and
(c) coverage for prostheses and physical complications of all stages of mastectomy, including lymph edemas; in a manner determined in consultation with the attending physician and the patient.

(12) **Nasal surgery** when Medically Necessary.

(13) Surgical Treatment of **Morbid Obesity** when Medically Necessary.

(14) **Prophylactic Surgery**

Diagnostic Services

(1) Diagnostic charges for **X-rays.**

(1) **Radiology,** ultrasound and nuclear medicine.

(3) **Pre-admission** testing (PAT).

(4) **Laboratory and pathology.**

(5) **EKG, EEG and other electronic diagnostic medical tests.**

(6) **Amniocentesis.**

(7) **Psychological** testing

(8) **Neuropsychological** testing

(9) **Allergy** testing.

(10) **Magnetic Resonance Imaging (MRI).**

Emergency Services

(1) Professional local **ambulance service** provided by a Hospital or by a government certified ambulance service to or from the Hospital, including both air and ground ambulance services, when such service is deemed by the Physician as Medically Necessary to safeguard the health of the Covered Person.

(2) Treatment in a hospital **emergency room** or other emergency care facility for a condition that can be classified as an Emergency.

(3) **Physician services,** and the treatment of an Injury or Illness which is the result of an Emergency.

Ambulance/Emergency Service Limitation – To be treated as a Covered Charge, Emergency transportation must be:

(a) Medically Necessary;
(b) within or between the United States, Canada and Puerto Rico;
(c) by a licensed professional ambulance service, regularly scheduled airline, air ambulance or railroad; and
(d) to the nearest facility where Emergency care or treatment is rendered.

Dental Services

(1) Services performed by a **Dentist or an oral surgeon** when required for:

(a) Accidental Injury to natural teeth and jaw within twelve (12) months after an Accident or as soon as reasonably possible. For a child requiring facial reconstruction due to dental related injuries there may be several years between the accident and the final repair.
(b) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
(c) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth
(d) Excision of benign bony growths of the jaw and hard palate.
(e) External incision and drainage of cellulitis.
(f) Incision of sensory sinuses, salivary glands or ducts.
(g) Surgical removal of bone or tissue impacted teeth.

Dental prosthetics are a covered expense when to needed to restore function after covered services are completed to make the participant whole. Dental implants are not a covered expense.

Provider Services

(1) **Services of a Physician**, while the Covered Person is an **Inpatient**, including surgical procedures, administration of anesthesia by a second Physician during surgery, treatments and other Physician's services received in a Hospital, excluding routine services or other care not connected with treatment of an Illness or Injury unless otherwise stated herein.

(2) **Physician services**, and the cost of the use of facilities, including surgical procedures and other Physician's services received in a Physician's office, the Covered Person's home, the Outpatient department of a Hospital, an Ambulatory Surgical Center, an urgent or immediate care center or a Hospital for inpatient services. Regarding outpatient office visit charges, one office charge per visit is payable under this Plan unless prohibited under the Patient Protection and Affordable Care Act.

(3) **Services of chiropractors** acting within the scope of their licenses, subject to any limitations set forth herein.

(4) Services of actively practicing **nurses** (other than persons who reside in the Covered Person's home or who are a member of the Covered Person's Immediate Family) as follows:

(a) In a Hospital, services of a Registered Professional Nurse (R.N.) or services of a Licensed Practical Nurse (L.P.N.);
(b) Other than in a Hospital, services of a Registered Professional Nurse (R.N.), a visiting nurses association, where available, or a Licensed Practical Nurse (L.P.N.)
(c) Other than in a Hospital, services of a certified Nurse Practitioner authorized to practice in the state in which services are furnished by a recognized national certifying body that has established standards for nurse practitioners

(5) The **Private Duty Nursing** care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to the extent of: *Outpatient Nursing Care.* Outpatient nursing care is subject to the Home Health Care limitations and maximums. Outpatient private duty nursing care on a shift-basis is not covered.

(6) **Midwife** delivery services, provided:

(a) The state in which such services are performed has officially recognized midwife delivery; and
(b) The person or persons performing such midwife delivery and the facility available for these services are properly licensed by the state at the time the delivery is performed.

(7) The charges of a legally qualified **physical, speech, occupational or orthopedic therapist**, if prescribed by a Physician. Therapy is covered only for purposes of restoring speech ability or improving a bodily Injury or Illness and only if the therapy is expected to result in significant improvement of the specific defects.

Spinal Manipulation/Chiropractic Services

(1) Chiropractic or Chiropractic Services means the diagnosis and analysis of any interference with normal nerve transmission and expression, the procedure preparatory to and complementary to the correction thereof by an adjustment of the articulations of the vertebral column, its immediate articulation, and includes other incidental means of adjustments of the spinal column and practice of drugless therapeutics. However, chiropractic does not include any of the following:

a) Prescription or administration of legend drugs or other controlled substances;
b) Performing of incisive surgery or internal or external cauterizatrion;
c) Penetration of the skin with a needle or other instrument for any purpose;
d) Use of colonic irrigations, plasmatics, ionizing radionics;
e) Conducting invasive diagnostic tests or analysis of body fluids except for urinalysis;
f) The taking of x-rays of an organ other than the vertebral column and extremities; and

g) The treatment or attempt to treat infectious diseases, endocrine disorders, or atypical or abnormal histology.
h) CAT scans and MRI's
i) Nerve conduction studies
j) Also, please note durable medical equipment, orthoptics and physical therapy can only be ordered by an MD.

Mental Health and Substance Abuse Services

(1) **Physician services** and the cost for the use of facilities, for **Inpatient** treatment of **mental and nervous conditions.**

(2) **Physician services** and the cost for the use of facilities, for **Outpatient** treatment of **mental and nervous conditions.**

(3) **Physician services** and the cost for the use of facilities, for **Inpatient** treatment of **substance abuse.**

(4) **Physician services** and the cost for the use of facilities, for **Outpatient** treatment of **substance abuse.**

(5) Professional services provided by a **Psychiatrist, Psychologist or other mental health therapist** licensed by the state where practicing and acting within the scope of such license.

(6) **Non-Residential** treatment facility services as specified herein.

(7) **Intensive Outpatient** treatment services, as specified herein.

(8) **Psychiatric Day Hospital** treatment services, as specified herein.

(9) **Partial Hospitalization** treatment services, as specified herein.

(10) Treatment for **Eating Disorders.**

(11) Treatment of Attention Deficit Disorder

Note: Two (2) days of treatment in a day treatment program will be considered as one (1) day of inpatient treatment (precertification is not required). "Day Treatment" means treatment of a mental illness in an intensive outpatient program primarily used to assist patients during an acute crisis. Further, 2 days of treatment in an Intensive Outpatient Program or Partial Hospitalization will be considered as 1 day of inpatient mental health or substance abuse treatment (precertification is not required).

This Plan will pay for treatment rendered in accordance with generally accepted standards of medical practice of Mental Health and Substance Abuse Disorders. Covered Services include:

(a) diagnostic and psychological testing;
(b) charges for room and board, services and supplies while confined as an inpatient;
(c) individual and group therapy; and
(d) electroshock therapy.

Therapy Services **Therapy services include, but are not limited to:**

(1) **Radiation** therapy through treatment of disease by X-ray, radium or radioactive isotopes.

(2) **Chemotherapy** by way of treatment of disease by chemical or biological antineoplastic agents.

(3) **Dialysis** for the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, including hemodialysis and peritoneal dialysis.

(4) **Respiratory/inhalation** therapy.

(5) **Occupational** therapy from a legally qualified physical therapist or assistant. The therapy must be ordered by a Physician and improve a body function. Covered expenses do not include recreational programs or maintenance therapy.

(6) **Speech** therapy from a legally qualified speech therapist or assistant to restore speech loss due to an illness, injury or surgical procedure. Therapy must be ordered by a Physician and follow either:

(a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than frenectomy), and;

(b) a Sickness that is other than a learning disorder.

(7) **Physical** therapy by a legally qualified physical therapist or assistant. Therapy must be in accord with a Physician's exact orders as to type, frequency and duration, and to improve a body function. Manual therapy is a covered expense only when it is one component of a Medically Necessary and covered comprehensive physical therapy treatment plan to treat a specific condition or Injury. A copy of the treatment plan must be provided upon request. Treatment is subject to any physical therapy limitations. Treatment must be provided by a legally qualified physical therapist. Manual therapy, in absence of other therapeutic modalities, is not covered under this Plan.

(8) **Human Growth Hormone** therapy with Medical Necessity and periodic submission of growth charts.

(9) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered:

(a) under the supervision of a Physician;

(b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery or recurrent symptoms;

(c) initiated within 12 weeks after other treatment for the medical condition ends; and

(d) in a Medical Care Facility as defined by this Plan.

(10) **Home (IV) Therapy.**

Medical Equipment and Prosthetic Devices

(1) Rental of **iron lung** or other **Durable Medical Equipment** that is appropriate for the home use and is made mainly to treat the ill or injured, or other durable equipment required for temporary therapeutic use, or the purchase of such medical equipment and its repair and replacement if economically justified, whichever is less. Routine maintenance is not covered and charges for deluxe items are limited to the cost of features considered basic and necessary to the intended function of the device.

(2) **Orthotic devices** including initial purchase, fitting and repair of braces, splints and other appliances used stabilize or immobilize a body part, prevent deformity, protect against injury, or assist with functions.

(3) **Orthopedic/Prosthetic devices** (except as stated as not covered in Section *Not Covered Services*) including crutches and prosthetic devices and appliances. Orthopedic shoes are covered if attached to a Medically Necessary brace. Non-prescription devices to be attached to or placed in shoes are not covered. Covered services also include the purchase, fitting, repair and initial placement of fitted devices which replace body parts or perform body functions, such as artificial limbs and eyes necessary for the alleviation of or correction of conditions arising out of Accidental Injury or Illness.

Wigs following cancer treatment are a covered expense, limited to one per Calendar Year. Dental prosthetics when to needed to restore function after covered services are completed to make the participant whole are a covered expense, however Dental Implants are not covered. Cochlear implants are a covered expense.

Other Medical and Related Supplies . *Including, but not limited to, the following:*

(1) Initial **contact lenses or glasses** required following cataract surgery.

(2) **Surgical dressings, osmotic supplies, electronic heart pacemaker, casts, splints and trusses.**

(3) Administration of **blood and blood plasma, blood transfusions**, including the cost of blood and blood plasma expander.

(4) **Oxygen** and rental of equipment required for its use, not to exceed the purchase price of such equipment.

(5) **Occupational** therapy supplies.

(6) Sterile **surgical supplies** after surgery.

(7) **Diabetic** supplies, including glucose monitors.

(8) **Contraceptive Devices**

Standard elastic stockings, garter belts and items of similar nature are not covered.

Pregnancy

(1) Services provided for any condition of pregnancy and the resulting childbirth, miscarriage, or involuntary abortion, including any complications therefrom **for all Covered Persons.**

(2) Hospital charges Incurred by a newborn during the initial period of Hospital Confinement, but not to exceed five (5) days, will be covered as charges of the mother. However, the newborn child must be added to the Eligible Employees coverage (per the terms set forth in section *Enrollment, Eligibility, and Termination of Coverage*) for the newborn charges to be considered under this Plan. In addition, the following services will be covered during the same time period: (a) professional services; and (b) circumcision.

The Plan will provide coverage for Hospital care, including room and board and pediatric visits, for a newborn infant and the mother during the first forty-eight (48) hours after a normal vaginal delivery and during the first ninety-six (96) hours after a caesarean section. This coverage is subject to the satisfaction of the mother's Coinsurance Deductible or Copayments where applicable and then is paid at the appropriate level of benefits subject to case management and accessing the PPO network. In the event of an early discharge, the Plan will cover two (2) R.N. home visits.

(3) Pre-admission certification for the condition of pregnancy is not required for hospital confinements which do not exceed the minimum required periods stated above. However, pre-admission certification is required for labor induction and days beyond the above time periods.

(4) Termination of pregnancy, only when the life of the mother would be endangered if the fetus were carried to term *(with doctor's statement)* or in cases of rape or incest *(with police report)*. Also medical complications resulting from voluntary termination of pregnancy, whether covered or not, are covered expenses.

Prescription Drugs and Medicines

(1) **Drugs and medicines** which require the written prescription of a Physician which are purchased from a licensed pharmacist or from a Physician who is licensed to dispense drugs unless specifically stated as not covered herein. All prescription drugs are subject to the limitations specified in Sections *Benefit and Information Grid* and *Prescription Drug Benefits.*

(2) **Injectable drugs** and the charge for administration when in lieu of an office visit charge .

(3) **Allergy serum** and the physician charge for the injection (when in lieu of an office visit charge).

(4) FDA approved self-injectable drugs are covered under the medical portion of this Plan unless specifically covered under the Prescription Drug Program or unless specifically stated otherwise elsewhere in the medical portion of this document.

Temporomandibular Joint Syndrome (TMJ)

(1) Reimbursements shall be limited to the applicable Copayment or Coinsurance percentage after application of the Deductible. Please Note: Orthodontia services are not covered under this benefit.

Routine/Wellness Services for Adults and Children. Including, *but not limited to*, the following services as recommended by a Physician:

Routine Physical Examinations – The Plan will reimburse expenses for a routine physical and related screening charges including school enrollment physical exams.

Routine and Non Routine Mammogram – A routine mammogram and the related charges will be covered one (1) time per Calendar Year or as physician recommended.

Routine Pap & Exam – The Plan will reimburse expenses for a routine pap (with urinalysis) and exam once each Calendar Year.

Routine Prostate (PSA) – The Plan will reimburse expenses for a routine prostate exam and related charges one (1) time per Calendar Year.

Routine Immunizations. – The Plan will reimburse expenses for routine immunizations that have in effect a recommendation from the Centers of Disease Control with respect to the individual.

Routine Eye Examination. – The Plan will reimburse expenses for one (1) dilated eye examination per Calendar Year for diabetic retinopathy and other disease abnormalities. This does not include exams for vision correction.

Routine Hearing Screening. – The plan will reimburse for routine hearing screenings.

Routine Colorectal Cancer Screening – The Plan will reimburse for routine colorectal cancer screenings and related laboratory test as physician recommended. Polyp removal if performed at the same time is a covered expense under this benefit.

Diabetic Self Management Training – The plan will reimburse for Medically Necessary diabetes self management training.

Organ and Tissue Transplants

(1) **Organ and tissue transplants** as set forth in Section *Organ and Tissue Transplant* .

Other

(1) Medically Necessary treatment of the **feet.**

(2) Covered charges include any **taxes or surcharges** imposed by a governmental entity based on the value or volume of Covered Services provided to Covered Persons, or amount imposed or assessed against the Plan or the Employer in lieu of such taxes or surcharges. Taxes or surcharges are not subject to Deductible or Coinsurance and are payable at 100%. *(Please Note: This benefit does not include surcharges, interest, late charges, claim form completion or missed appointment charges from a provider).*

(3) Treatment of or related to **sleep disorders** when Medically Necessary.

(4) **Medically Necessary patient education programs** including, but not limited to ostomy care education covered one (1) time initially with follow-up as directed by a Physician.

(5) Services and Supplies related to the treatment of **Autism or Asperger's Syndrome** (Residential placement and educational and recreational therapy services for pervasive development disorders not included). Covered services will be provided as prescribed by the Covered Persons treating physician in accordance with a treatment plan.

Unified Group Services

Services listed as a covered expenses in this section that are not listed in Section Benefit and Information Grid are payable at the applicable Coinsurance level, after satisfaction of Deductible (if applicable), subject to access of the PPO Network and the precertification requirements of this Plan.

ORGAN AND TISSUE TRANSPLANTS

Covered Charges for organ and tissue transplant surgeries and related expenses other than Cornea and Kidney shall be subject to the Organ and Tissue Transplant Maximum Lifetime limit of $1,000,000 per Covered Person and Coinsurance and Deductible amounts otherwise applicable under this Plan. Covered charges for cornea and Kidney transplant surgeries and related expenses shall be subject to the Plan Lifetime Maximum of $5,000,000. Out-of-Network transplants other than Kidney and Cornea shall be further limited to the Benefit maximums in the below Schedule:

Adult Procedures – Includes Organ/Tissue Acquisition	**Out-of-Network Maximum Charge Payable by Plan**
• Adult Heart	$68,000
• Adult Lung	$97,000
• Adult Heart/Lung	$133,000
• Adult Liver	$97,600
• Adult Pancreas	$75,200
• Kidney/Pancreas (Kidney not included in limitation)	$75, 200
• Adult Autologous Bone Marrow including high dose chemotherapy	$56,000
• Adult Related Allogeneic Bone Marrow including high dose chemotherapy	$80,000
• Adult Unrelated Allogeneic Bone Marrow including high dose chemotherapy	$88,000

Child Procedures – Includes Organ/Tissue Acquisition	**Out-of-Network Maximum Charge Payable by Plan**
• Pediatric Autologous Bone Marrow including high dose chemotherapy	$66,400
• Pediatric Related Allogeeic Bone Marrow including high dose chemotherapy	$93,600
• Pediatric Unrelated Allogeneic Bone Marrow including high dose chemotherapy	$115,200
• Pediatric Liver	$106$400
• Pediatric Heart	$104,000

Covered Services for Organ and Tissue Transplants

The following services are Covered Services:

(1) Inpatient and Outpatient Hospital services;

(2) services of a Physician for diagnosis, treatment, and surgery for a covered transplant procedure;

(3) diagnostic services;

(4) services provided to a living donor of an organ or tissue, as specified in more detail below;

(5) procurement of an organ or tissue, including services provided by a living donor of an organ or tissue for procurement of an organ or tissue. Covered Services are limited to the actual procurement expenses and benefits are subject to the maximums stated in this section of the Plan;

(6) reasonable and necessary transportation costs for travel (including meals and lodging, up to a maximum of $200 per day) to and from the site of the surgery for a covered transplant procedure for the transplant recipient and one companion (two if the recipient is a minor), up to a maximum of $10,000 per covered transplant procedure. Itemized receipts in a form satisfactory to the Employer must be submitted for reimbursement. Travel expenses related to Out-of-Network Transplant facilities will be paid at the Out-of-Network transplant percentage.

(7) private duty nursing by a registered nurse or a licensed practical nurse when recommended by a Physician, up to a maximum of $10,000 per covered transplant procedure. The nurse cannot be a family member of the recipient or normally live in the recipient's home. Inpatient private duty nursing is a covered service only if the Hospital's regular staff cannot provide the care needed due to the recipient's condition;

(8) rental or Durable Medical Equipment for use outside the Hospital. Covered charges are limited to the purchase price of the same equipment;

(9) prescription drugs, including immunosuppressive drugs;

(10) oxygen;

(11) speech therapy, autotherapy, visual therapy, occupational therapy, physical therapy, and chemotherapy, as defined in herein. Speech therapy for voice training or to correct a lisp is not a covered service;

(12) services and supplies for high dose chemotherapy when provided as part of the treatment plan which includes stem cell transplantation;

(13) surgical dressings and supplies; and

(14) Home Health Care.

Donor Coverage

Charges for obtaining donor organs are covered charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by that payable under the donor's plan. If the organ donor is a Covered Person and the recipient is not, the Plan will not cover charges incurred for obtaining donor organs from the Covered Person

(1) evaluating the organ;
(2) removing the organ from the donor;
(3) transportation of the organ from within the United States and Canada to the place where the transplant is to take place;
(4) transportation of the patient and a companion (two companions if the patient is a minor) to and from the site of the transplant including the cost of meals and necessary lodging, up to a maximum of $200 per day;
(5) private nursing care by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for any transplant procedure; and
(6) procurement of donor organ or tissue.

Limitations

Transplant limitations include the following:

(1) If a covered transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefit will be paid for transplant services until the earlier of a) the recipient's death; or b) the date the decision is made by the recipient's Physician not to perform the transplant.

Exclusions

In addition to the exclusions stated in Section *Services Not Covered*, no benefits are provided for:

(1) services and supplies for a transplant which is Experimental and/or Investigational;

(2) services and supplies which are eligible to be repaid under any private or public research fund, whether or not such funding was applied for or received; or

(3) services and supplies of any provider located outside the United States of America, except for procurement services. The maximums for procurement services will apply to procurement services provided by a provider located outside of the United States of America.

PRESCRIPTION DRUG BENEFITS

Participating Pharmacy Discount

Prescriptions drugs that require a physician's prescription and that are dispensed by a Pharmacist are covered under this portion of the Medical Plan. This benefit is not subject to the Pre-Existing Conditions Limitation. 100% will be payable after satisfaction of the appropriate Copayment. Any one prescription is limited to the greater of a 30-day supply or a 100-unit dose, unless the medication is a maintenance drug (those medications that are taken for long periods of time such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc). Maintenance medications will be defined as any prescription drug taken more than thirty-one (31) days.

Limits to this Benefit. This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.
(2) Refills up to one year from the date of order by a Physician.
(3) Any one-prescription drug is limited to the greater of a thirty (30) day supply or 100-unit dose through a local pharmacy or, if purchasing a maintenance medication, the greater of a ninety (90) day supply or 310-unit dose which is available through the mail order drug benefit option.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those medications that are taken for long periods of time such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc). Because of volume buying, the pharmacy network is able to offer significant savings on prescription drugs. Maintenance medications will be defined as any prescription drug taken more than thirty-one (31) days.

Maintenance legend drugs may be dispensed in maximum quantities of 90-day supply. These may be filled only through the Mail Order Pharmacy and will be payable at the Copayment specified in this section and in Section *Benefit and Information Grid.*

Non-Pharmacy Network Benefit

Submit to the Plan for reimbursement of the discounted drug amount less the appropriate Copayment

PLEASE NOTE: Prior Authorization

Some prescription drugs may be covered only if approved by Prior Authorization. If you find your prescription requires Prior Authorization, please place a telephone call to your claims account manager at Unified Group Services, Inc. so he/she may assist you with this process.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) A charge excluded under Medical Plan Exclusions.
(2) A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
(3) Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
(4) A drug or medicine labeled "Caution – limited by federal law to investigational use".
(5) Experimental drugs and medicines, even though a charge is made to the Covered Person.
(6) Any charge for the administration of a covered Prescription Drug.
(7) Any drug or medicine that is consumed or administered at the place where it is dispensed.
(8) A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
(9) A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
(10) A charge for fertility medication.
(11) Immunization agents or biological sera.
(12) Amphetamines and appetite suppressants.
(13) A charge for vitamins that do not require a prescription under Federal Law.

SERVICES NOT COVERED

The Plan does not cover charges for any of the following services:

Note: A comprehensive list of all exclusions related to Organ and Tissue Transplants is shown in the Section *Organ and Tissue Transplants.*

Note: A comprehensive list of all exclusions related to Prescription Drugs is shown in the Section *Prescription Drug Benefits.*

(1) Services and supplies rendered for any condition, disability, or expense resulting from Injury or Illness caused by **war**, declared or undeclared, or any act of war or by participating in **civil insurrection or a riot.** An act of terrorism will not be considered an act of war, declared or not declared.

(2) Services and supplies in a Hospital owned or operated by **the United States government or any government outside the United States** in which the Covered Person is entitled to receive benefits, except for Usual & Customary Charges for services, and supplies which are billed, pursuant to federal law, by the Veterans Administration or the Department of Defense of the United States, for services and supplies which are covered herein and which are not Incurred during or as a result of service in the Armed Forces of the United States.

(3) Services and supplies rendered while a member of the **armed forces** of any state or country.

(4) Services, medicines or supplies paid or payable under any **Other Plan,** except as provided herein under Section *Coordination with Other Plans and Benefits*, of the Plan. This exclusion shall apply, regardless of whether the person covered under this Plan is covered under such Other Plan, or is merely the spouse or dependent of such person.

(5) Services and supplies provided to the extent that the Covered Person is reimbursed, entitled to reimbursement, or in any way indemnified for these expenses by or through any **public plan,** including Medicare, in accordance with applicable laws.

(6) Services provided for which payment or reimbursement is received by or for the account of the Covered Person as the result of a **legal action or settlement.**

(7) To the extent permitted by applicable law, services and supplies rendered for any condition, Disability or expense resulting from or sustained as a result of being engaged in an **illegal occupation,** commission of or attempted commission of an assault or an **illegal act** unless resulting from an act of domestic violence or a physical or mental medical condition as would be prohibited under the Health Insurance Portability and Accountability Act of 1996.

(8) Services or supplies that are **prohibited by any law** of the jurisdiction in which the Covered Person resides at the time the charge is Incurred.

(9) Services and supplies rendered as a result of a voluntary **self-inflicted Injury or attempted suicide** unless resulting from a physical or mental medical condition as would be prohibited under the Health Insurance Portability and Accountability Act of 1996.

(10) Services, medicines or supplies for any Injury received in an **Accident** *(except for Covered Charges not payable by any other policy or as provided in section Subrogation Rights).*

(11) Services or supplies rendered for an Illness or Injury that is an **occupational Illness** or **an occupational Injury which are payable by another Plan or policy.**

(12) Services or supplies for any occupational condition, Accident, disease, ailment, Illness or Injury arising out of and in the course of employment, if covered under a Worker's Compensation policy, or services, medicines or supplies which are furnished without cost to a Covered Person under the laws of the United States or any other country or of any state or political subdivision thereof.

(13) Services and supplies rendered to an individual prior to the **Effective Date** of the Plan or the Covered Persons effective date of coverage.

(14) Services and supplies provided for any operation, procedure, treatment, facility, drug, device or supply **not** generally accepted as **standard medical treatment** under the professional standards of medical practice for the condition being treated at the time Incurred for the geographic location of the principal office of the Company, or any items requiring United States federal or other United States governmental agency approval which approval has not been granted as of the time services are provided.

(15) Care and treatment that is either **Experimental/Investigational** or not Medically Necessary.

(16) Services and supplies which are **not Medically Necessary** for the diagnosis or treatment of Illness or Injury.

(17) **No Physician or Provider recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician or Provider; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician or Provider. Regular care means ongoing medical supervision or treatment, which is appropriate care for the Injury or Sickness.

(18) Any **limitation** as defined under the Section *Covered Services.*

(19) **Expenses used to satisfy Plan Deductibles or Copayments (if applicable).**

(20) Services for which charges are made which are in excess of the **Usual & Customary Charges.**

(21) Services and supplies **not specifically listed** as Covered Services in this Plan.

(22) **Complications of non-covered treatments.** Care, services or treatment required as a result of or complications from a treatment not covered under this Plan, (with the exception of complications during pregnancy of a Covered Dependent) unless otherwise required by law.

(23) **Room and board** charge for days in which the Covered Person is permitted to leave a health care facility (a weekend pass, for example).

(24) **Organ transplant** expenses as defined in non-covered expenses in the Section *Organ and Tissue Transplants.*

(25) Services rendered or performed or supplies ordered by anyone **other than a Physician or Dentist or other provider** as defined herein.

(26) **Professional services** performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person's Immediate Family, whether the relationship is by blood or exists by law.

(27) Professional services billed by a **Physician or nurse** who is an Eligible Employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(28) Standby charges of a **Physician.**

(29) Any **chiropractic services** in excess of the amount shown in the covered benefits for Chiropractor/Spinal Manipulation Limitations.

(30) **Laboratory testing** in connection with services performed by a licensed **chiropractor.**

(31) **Pre-marital laboratory testing.**

(32) **Genetic testing and counseling** that is without Medical Necessity.

(33) **Radial keratotomy** or other **eye** surgery to correct near-sightedness or far sightedness. **Eye examinations** for the diagnosis or treatment of a refractive error, including the fitting of eyeglasses or lenses, orthoptics, vision therapy, or supplies, unless such treatment is due to a covered Illness or accidental Injury or is

otherwise covered as specified herein. This exclusion does not apply to aphasic patients and soft lenses or sclera shells intended for use as corneal bandages.

(34) **Orthopedics/Orthotics/Prosthetics**, replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or unless growth and development of a child necessitates replacement.

(35) Services and supplies for the **removal of bunions (except by capsular or bone surgery), toe nails (except for surgery for ingrown nails), corns or calluses or the trimming of toenails**, unless needed in treatment of a metabolic or peripheral-vascular disease.

(36) **Orthopedic** shoes, orthopedic devices to be attached to or placed in shoes unless they are an integral part of a leg brace; treatment of weak, strained, flat, unstable or unbalanced feet.

(37) **Speech therapy** for behavioral or learning disabilities unless specifically stated otherwise elsewhere in this document.

(38) **Marriage, sex or family counseling.**

(39) **Infertility treatment.** For the diagnosis or treatment of, including, but not limited to, **in vitro fertilization, artificial insemination, embryo implantation, gamete intra fallopian transfer (GIFT),** and any related expenses, medications, or testing beyond the period to diagnose the condition. "Treatment of infertility" means the use of methods which do not correct the inability to conceive, but create the conditions for the individual to conceive by stimulating the individual's natural reproductive system or by implementation. Methods used to correct the inability to conceive are not subject to the limitation.

(40) **Reversal of voluntary or elective sterilization** and the use of a **surrogate mother** for Covered Persons or non-Covered Persons and any related expenses.

(41) **Services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.**

(42) Cosmetic surgery **or related Hospital admissions** unless Medically Necessary for:

(a) Correction of congenital deformity resulting from disease, birth defects or previous medical treatment while less than twelve (12) years of age, provided that it is not Medically Necessary to delay the procedure, for conditions resulting from injuries or traumatic scars; or

(b) Reconstructive surgery as Medically Necessary for the treatment of a diseased condition, functional disorder, Accidental Injury or to restore bodily function *(see page 16-17).*

(43) Any services performed in connection with the enlargement, reduction or change in **appearance of a portion of the body**, including, but not limited to the breasts, lips, jaw, chin, nose or ears unless Medically Necessary.

(44) **Surgical excision or reformation** of any sagging skin of or on any part of the body, including, but not limited to the eyes, face, neck, abdomen, arms, legs or buttocks, unless Medically Necessary.

(45) Care and treatment for **hair loss** including hair transplantation, wigs or any drug that promises hair growth, unless Medically Necessary and prescribed by a Physician (other than one (1) wig following chemotherapy).

(46) **Chemical face peels or abrasion** of the skin.

(47) **Electrolysis.**

(48) **Personal hygiene and convenience items**, such as air conditioners, humidifiers, hot tubs, whirlpools, swimming pools or physical exercise equipment, even if such items are prescribed by a Physician.

(49) Hospitalization for environmental change or Physician charges connected with prescribing an **environmental change.**

(50) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

(51) Hospital and surgical services rendered for the treatment of **obesity and/or weight control unless Medically Necessary for Treatment of Morbid Obesity.**

(52) **Weight control** programs, amphetamines and appetite suppressants unless Medically Necessary for treatment of Morbid Obesity.

(53) **Fluoroscopy** without films.

(54) Charges for **Laetrile** and its administration.

(56) Vitamins, aspirin, nutritional supplements and other substances **not requiring a prescription by federal law.**

(57) Any drug which is consumed at the time and place of the **prescription** order.

(58) Any **drug or medicine** which is not required in and for the treatment of bodily Injury or Illness including, but not limited to, fertility drugs, *unless specifically stated otherwise elsewhere in this document.*

(59) **Drugs, medicines** or injectable insulin dispensed in a quantity or an amount, which is in excess of that quantity or amount specified by the prescribing Physician.

(60) **Drugs, medicines** or injectable insulin, which are not approved under the United States Food and Drug Act, or its successor.

(61) Services derived from **Illegal use** of narcotics or use of hallucinogens in any form (unless prescribed by a Physician).

(62) **Drugs, medicines** or injectable insulin for an occupational Injury or Illness.

(63) **Drugs, medicines** or injectable insulin to the extent that benefits are payable for the same Covered Service under the provisions of another section of this Plan.

(64) **Drugs, medicines** or injectable insulin which are obtained for any condition, disease, ailment or Accidental Injury for which coverage is available in whole or in part under any Worker's Compensation laws or similar legislation.

(65) **Prescription Drugs**, as defined in non-covered expenses in the Section *Prescription Drug Benefits unless specifically stated as covered under the medical portion of this Plan elsewhere in this document.*

(66) Voluntary abortions

(67) **Hypnosis or Biofeedback.**

(68) **Hearing aids** and exams for their fitting or related supplies.

(69) **Custodial care**, which is care whose primary purpose is to meet personal rather than medical needs and which can be provided by a person with no special medical skill or training.

(70) **Telephone consultations, charges for the completion of claim forms or charges for failure to keep scheduled appointments. Radio, television, telephone, and guest meals.**

(71) **Travel expenses** for a Covered Person, whether or not recommended by a Physician, or for a Physician.

(72) Charges for **self-help training** or other forms of non-medical self-care other than specifically listed in the Plan.

(73) Treatment of **sleep disorders** that is **not** Medically Necessary.

(74) Charges for which the Plan has **no legal obligation to pay.**

(75) Care and treatment for which **there would not have been a charge if no coverage had been in force.**

(76) Charges for illnesses or injuries suffered by a Covered Person due to the action or inaction of any party if the **Covered Person fails to provide information as specified in Section *Subrogation.***

(77) Claims **not submitted within the Plan's filing limitation** as specified in Section *Administration of the Plan.*

(78) Charges for services rendered **outside the United States** ***if*** the Covered Person traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

(79) Charges or disabilities for or in connection with an injury arising out of or in the course of any **employment for wage or profit.**

(80) **Recreational or diversional therapy.**

(81) **Court ordered Substance Abuse treatment** or other treatment or care lacking a collaborating diagnosis from a Physician

(82) Expenses **covered by medical coverage provided through "no fault" auto coverage.**

(83) Dental Implants

(84) The Plan will not pay for any charges which have been refused by another plan covering the Covered Person as a **penalty assessed due to non-compliance** with the plans rules and regulations if shown on the primary carrier's explanation of benefits.

(85) If the **primary plan has a restricted list of healthcare providers** and the Covered Person chooses not to use a provider from the primary plans restricted list, this Plan will not pay for any charges disallowed by the primary plan due to the use of such provider, if shown on the primary carrier's explanation of benefits.

(86) Physical exams or immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs or other purposes not otherwise permitted elsewhere in this Plan document.

(87) Treatment in a **Residential Treatment Facility** or supervised living or halfway house.

(88) Services resulting form a nuclear explosion or nuclear accident.

(89) Services for care required while incarcerated in a federal, state or local penal institution or while in custody of federal, state or local law enforcement authorities, including work release programs.

(90) Care received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, or similar person or group.

(91) Services which are solely performed to preserve the present level of function or prevent regression of function for an illness or injury or condition which is resolved or stable.

(92) Services and supplies primarily for educational, vocational or training purposes except as specified herein.

(93) Related to artificial and or mechanical hears or ventricular and atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to left ventricular assist devices (LVAD) when used as a bridge to a heart transplant.

(94) Services related to male or female sexual or erectile dysfunctions except prescription drugs will be a covered expense.

(95) Services or supplies related to alternative or complementary medicine, including acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapyl, massge therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

(96) Scherotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studes to asses the result of ongoing treatments.

(97) Treatment of telangiectatic dermal veins (spider veins) by any method.

(98) Inpatient private duty nursing

DENTAL BENEFITS

DENTAL BENEFITS PLAN		
Calendar Year Deductible	None	
Calendar Year Maximum	$1,500 per Covered Person	
Lifetime Orthodontia Maximum	$1,000 per Covered Person Does not apply to Calendar Year Maximum Orthodontia services limited to children under age 19	
Reimbursement Schedule	Class I - Diagnostic/Preventive	100% paid by Plan
	Class II -- Basic	80% paid by Plan
	Class III -- Major	50% paid by Plan
	Class IV -- Orthodontia	50% paid by Plan

Dental Charges

Dental charges are the Usual and Customary Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as covered dental services. Benefits are payable up to the Maximum allowable charge for each Covered Person. Benefits payments are subject to the Deductible, if applicable, Co-insurance or cost share percentage and maximums amounts shown in section *Benefit and Information Grid,* subject to the terms and conditions, limitations and exclusions that are described in this section and in section *Not Covered Services.*

A dental charge is Incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Plan Supervisor will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be Incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class I: Preventive and Diagnostic Dental Services

The limits on Basic Services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

(1) Routine dental exams. (2 exams per Calendar Year).
(2) Dental cleanings. (2 per any 12-month period).
(3) Topical fluoride for Dependent children under age 16. (2 per Calendar Year).
(4) X-rays:
    Bitewings (up to four limited to 1 time per any Calendar Year).
    Full-mouth/Panorex (1 per any 60-month period).
    Periapical x-rays (benefit not payable when performed on same day as a panoramic film or complete series.)
    Occlusal x-rays
    Extraoral x-rays (2 films per Calendar Year)
(5) Space Maintainers for children under age 12.
(6) Diagnostic lab procedures.
(7) Dental sealants limited to children under age 16 and two applications per tooth per lifetime.

Class II: Basic Dental Services

(1) Palliative Treatment/Emergency Care (and exam) limited to two treatments per Calendar Year.
(2) Consultations, limited to once per provider.
(3) Office visit for observation, limited to two visits per Calendar Year. (not covered when associated with other services or procedures.
(4) Diagnostic Casts limited to one (1) time every 24 month period.
(5) Restorative services (fillings).
(6) Pin Retention
(7) Simple Extractions.
(8) Surgical Extractions *(the medical plan will pay 1st if applicable, dental plan 2nd (not exceeding 100%)).*
(9) Pulpotomy
(10) Endodontics.
(11) Root Recovery
(12) Alveoplasty
(13) Incision and Drainage
(14) Removal of Cyst
(15) General Anesthesia
(16) Intravenous Sedation
(18) Periodontics.
(19) Repair/recement/restorative.
(20) Reline and tissue conditioning for partial or full dentures.
(21) Occlusal guards

Class III: Major Dental Services

All services listed below include temporaries and twelve (12) month follow-up care.

(1) Gold Foil
(2) Gold Inlays and Onlays
(3) Porcelain Restorations
(4) Crowns
(5) Gold Post and Core
(6) Full Dentures
(7) Partial Dentures
(8) Fixed Bridges
(9) Dental Implant
(10) Stainless Steel Crowns

Class IV: Orthodontic Dental Services

The following orthodontic services are covered by the Plan for covered Dependent children up to the age of nineteen (19):

(1) necessary services related to an active course of orthodontic treatment.
(2) models and radiographs.
(3) cleanings.
(4) adjustment of orthodontic appliances.
(5) retention treatment.

For purposes of this provision, each active course of orthodontic treatment is the period of time that begins when the first orthodontic appliance is installed and ends when the active appliance is removed. The initial payment will be the listed down payment (if a down payment is not listed, 25% of the total will be considered) and the remaining treatment will be divided in to monthly installments, not to exceed the orthodontic maximum benefit per Covered Person under the age of nineteen (19).

Alternate Procedures

The Plan may limit payment of benefits to an amount that is less expensive than the proposed treatment if:

1. A less expensive alternate procedure, service or course of treatment can be performed in place of the proposed treatment to correct a dental condition; and
2. the alternate treatment can produce a professionally satisfactory result.

Predetermination of Benefits

Before starting a dental treatment for which the charge is expected to be $500 or more, a predetermination of benefits form can be submitted but is not a plan requirement.

A regular dental claim form is used for the predetermination of benefits. The Covered Eligible Employee fills out the Eligible Employee section of the form and then gives the form to the Dentist.

The Dentist should itemize all recommended services and costs and attach all supporting x-rays to the form and send the form to the Claims Supervisor at this address:

Unified Group Services, Inc.
P.O. Box 10
Pendleton, IN 46064-0010
(800) 291-5837

The Claims Supervisor will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

Exclusions

A charge for the following is not covered:

(1) Procedures that are not included in the classes of eligible dental expenses as described in this section, that are not necessary, or are not the treatment customarily recognized by the dentist's field of specialty as essential to treating the condition;
(2) Any portion of a service charge that is in excess of the maximum allowable charge;
(3) Crowns, inlays or onlays for: teeth that can be restored by other means; the purpose of periodontal splinting; or the correction of abrasion, attrition or erosion;
(4) Procedures relating to the charge of vertical dimension, the restoration of occlusion, bite restoration, or bite analysis;
(5) Congenital malformations;
(6) Cosmetic procedures;
(7) The replacement of permanent full and partial dentures, bridges, inlays , onlays or crowns during the first 12 months of coverage under this Plan; thereafter, replacement within 5 years of last placement (unless accidental injury);
This exclusion does not apply if replacement is necessary because of extraction of a functioning natural tooth.
(8) The replacement of temporary bridges, partials or dentures (with another temporary) if in place more than one year;
(9) The replacement of permanent bridges, full and partial dentures, crowns, inlays or onlays that can instead be repaired and restored to natural function;
(10) Replacement of lost or stolen appliances, replacement of orthodontic retainers, myofunctional therapy, athletic mouthguards, precision or semi-precision attachments, denture duplication, treatment of fractures, treatment of cysts, orthognathic surgery, or for temporomandibular joint dysfunction (TMJ), craniomandibular joint dysfunction, myofacial pain syndrome and all related conditions;
(11) Oral hygiene instruction, plaque control completion of claim forms, missed appointment and infection control;
(12) Services incurred before coverage for the class of eligible dental services is in effect, except as specifically provided;
(13) Hospital expenses and related anesthetic expenses;
(14) Services not completed by the end of the month when coverage terminates. This includes, but is not limited to the insertion of crowns, bridges, dentures, inlays, onlays or appliances and any related service or charge;
(15) Procedures that are begun but not completed;
(16) Any dental procedure for which benefits are payable under the medical provisions of the Plan;
(17) Procedures performed by a dentist who is a family member or for whose services there would be no charge without this coverage;

(18) For treatment provided without charge;
(19) For services caused by war or any act or war, whether declared or undeclared, or because of an accident while on full-time duty in the armed forces of any country;
(20) For care and treatment for which you are entitled to, or are eligible for, benefits under any Worker's Compensation Act or similar law;
(22) Injection of antibiotic drugs;
(23) Nitrous Oxide
(24) Vizalite
(25) Athletic mouth guards or appliances to control thumb sucking or other harmful habits

COST CONTAINMENT FOR HOSPITAL & SURGICAL SERVICES

The Company shall designate an entity or individual to perform utilization review services. In addition to the general precertification requirements described in the *Case Management* Section, Covered Persons are required to take the following steps with respect to review of proposed medical care-:

Pre-admission certification is required for all Inpatient admissions and surgeries, Outpatient surgeries (other than in physician's office), Outpatient MRIs, CT Scans, and PET Scans. Further, it is recommended to certify in advance any First Trimester Maternity and Outpatient chemotherapy and radiation therapy. The pre-admission certification is designed to confirm Medical Necessity; appropriateness of requested length of stay and appropriateness of proposed location of care.

Certification does not guarantee coverage and/or payment for respective Hospital admission or related charges. Eligibility, as well as any applicable limitations or exclusions on coverage are determined by Plan benefits. This process should be completed seven (7) days in advance of the planned procedure, but not less than one (1) day prior to the planned admission. For Emergency admissions, certification is required within forty-eight (48) hours (or the next business day).

PLEASE NOTE: Pre-admission certification for the condition of pregnancy is not required for hospital confinements which do not exceed the minimum required periods of forty-eight (48) hours for a normal delivery and ninety-six (96) hours for a caesarean section. However, pre-admission certification is required for labor induction and days beyond the above time periods.

Concurrent Stay Review/Discharge Planning. Concurrent stay review and discharge planning are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Hospital stay and coordinate with the attending Physician, Hospital, and Covered Person. If the attending physician feels that it is Medically Necessary for a Covered Person to stay in the Hospital for a greater length of time than has been precertified, the attending physician must request the additional days.

Large Case Management. When a catastrophic condition, such as a spinal cord Injury, a degenerative Illness, or a neurological paralytic disease occurs, a person will require long-term, perhaps lifetime care. After the person's condition is stabilized in the Hospital, he or she might be able to move to another type of care setting or to the person's home.

Sometimes specialized care or adaptations to the home are required, but are not covered under the Plan. The Large Case Management program was initiated for those situations in which there would be a large cash outlay for non-Covered Expenses for catastrophic conditions. It is a way in which these non-Covered Expenses can be paid by the Plan. However, the Plan Administrator, attending Physician, patient, and patient's family must all agree to the alternate treatment plan. Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Cost Containment Services Phone Number. 800-944-9401

The patient or family member must call this number to receive certification of the above listed cost management services. This call must be made at least one (1) day in advance of a non-emergency Hospitalization or within two (2) business days after an emergency Hospitalization. Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

The following information will be expected at time of Pre-certification:

(1) the name of the patient and relationship to the Covered Eligible Employee;
(2) the name, Social Security number and address of the Covered Eligible Employee;
(3) the name of the Employer;
(4) the name and telephone number of the attending physician;
(5) the name of the Hospital and proposed date of admission;
(6) the diagnosis and/or type of surgery and;
(7) the proposed length of Hospital stay.

CASE MANAGEMENT

The purpose of this Case Management Section is to protect the financial integrity of the Plan by limiting coverage, in those instances in which there are alternative courses of medical treatment, to services and supplies Incurred in connection with the most cost effective course of medical treatment.

Case Management. "Case Management" means with respect to a Covered Person:

(1) the review by the Plan Supervisor or Case Manager of the course of medical treatment proposed with respect to that Covered Person;

(2) consideration of available alternative courses of medical treatment; and

(3) the determination of the extent to which:

(a) services and supplies that would otherwise be Covered Services shall be limited because there is a more cost effective course of medical treatment; and

(b) services and supplies Incurred with respect to an alternative course of medical treatment should be covered under this Plan in lieu of those services and supplies Incurred with respect to the proposed course of medical treatment.

Case Manager. "Case Manager" means the individual or entity appointed by the Plan Supervisor to provide Case Management services. The appointment of a Case Manager shall be evidenced by a written agreement between the Case Manager and this Plan.

Applicability. Case Management shall apply with respect to services or supplies rendered to any Covered Person to the extent that the Plan Supervisor or Case Manager, in its sole discretion, determines that the cost to the Plan of reimbursing such Covered Person for Covered Charges may be reduced as a result of the application of Case Management.

Effect of Case Management. Notwithstanding anything in this Plan to the contrary, with respect to any Covered Person to whom Case Management applies, Covered Services shall be limited to those services and supplies approved in advance by the Plan Supervisor or Case Manager. In addition, services and supplies that are not otherwise described in Section *Covered Services* (or that are described in Section *Services Not Covered*) shall be treated as Covered Services if such services and supplies are Incurred with respect to a course of medical treatment that, in the sole discretion of the Plan Supervisor or Case Manager, is more cost effective than the other available alternative courses of medical treatment.

No Liability. Each Covered Person shall be responsible for all decisions relating to his medical care, and nothing in this Plan (including this Case Management Section) shall be construed to restrict or prohibit a Covered Person from choosing a particular course of medical treatment. No Case Management decision made by the Plan Supervisor or Case Manager shall be deemed to be the rendering of medical advice or the prescribing of a course of medical treatment.

CONTINUATION OF COVERAGE.

In order to comply with the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, this Plan allows for continuation of coverage for certain individuals whose coverage otherwise would terminate.

Qualifying Events. The right to elect continuation of coverage is triggered by the occurrence of one of the following "Qualifying Events" which otherwise would cause a Covered Person to lose coverage under the Plan:

1. Death of the Eligible Employee;
2. The Eligible Employee's termination of employment (for a reason other than gross misconduct) or reduction in hours to less than the minimum required for eligibility;
3. Divorce or legal separation of the Eligible Employee from the Eligible Employee's spouse;
4. The Eligible Employee becoming entitled to Medicare benefits;
5. A dependent ceasing to be an Eligible Dependent Child as described in the Section Eligibility, Enrollment, and Termination of Coverage;
6. The end of a leave of absence by the Eligible Employee under the Family and Medical Leave Act of 1993; or
7. The beginning of a military leave of absence by the Eligible Employee.

Notification Requirements / Election. The Eligible Employee or Dependent must notify the Company of a divorce, legal separation, or loss of Eligible Dependent Child status within sixty (60) days of the Qualifying Event. This notice must be provided in writing to Delaware County Government, Human Resource Department, 100 W. Main Street, Room 208, Muncie, IN 47305 and must be accompanied by written documentation proving that such an event has occurred. Failure to provide such notice to the Company will result in a forfeiture of rights to continuation of coverage under this Section.

Within fourteen (14) days of a Qualifying Event (or of receiving notice of a Qualifying Event), the affected Covered Persons will be notified of their rights to continuation of coverage and the process required to elect continuation of coverage. The affected Covered Persons will have sixty (60) days from the date coverage under the Plan otherwise would terminate or the date the notification is received, whichever is later, to decide whether to elect continuation of coverage. Such an election must be received or postmarked on or before the last day of the sixty (60) day period.

For families that would lose coverage without an election, each family member separately can elect continuation of coverage. However, unless otherwise specified in the election, an employee's election to continue coverage will be deemed to include an election of continuation for the employee's spouse and dependent children. Similarly, a spouse's election to continue coverage will be deemed to include an election of continuation for any dependent children covered by the Plan. Such an election on behalf of a family member is binding on that family member. Although an employee and spouse can elect by default to continue coverage on behalf of other family members, they cannot elect by default to decline coverage on behalf of other family members. For example, if an employee declines continuation coverage but does not address coverage for a spouse and dependent children, the spouse and dependent children still can elect to continue their coverage.

Cost. Except as provided below in the Subsection Extension for Disability, anyone who elects continuation of coverage must pay the entire cost of the coverage plus a two percent (2%) administrative fee. For purposes of determining such costs, a person originally covered as an employee or as a spouse must pay only the rate applicable to an employee if coverage is continued for only that one person. Similarly, each child continuing coverage independent of a family unit must pay only the rate applicable to a single employee.

The first payment is due within forty-five (45) days after the election for continued coverage, and will apply from the date continued coverage begins through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are due monthly by the first day of each month.

Effective Date. When continued coverage is elected and the costs paid within the required time limit, the continued coverage becomes effective retroactively to the date of the loss of normal coverage so that no break in coverage occurs.

Family Members Acquired During Continuation. A spouse or Eligible Dependent Child newly acquired during continuation coverage may be enrolled as a dependent. The standard enrollment provisions of the Plan apply during the period of continuation coverage.

Length of Continuation Period. Upon election and subsequent payment of premiums, continuation coverage may be continued on a monthly basis for up to thirty-six (36) months unless normal coverage under the Plan was lost because of termination of employment or reduction in hours. In that case, continuation coverage may be continued for up to eighteen (18) months. If,

during that eighteen (18) months, another Qualifying Event occurs, coverage may be continued up to another eighteen (18) months. In no case may the total period of continued coverage be more than thirty-six (36) months total.

When the Qualifying Event is the termination of employment or reduction of the employee's hours of employment, and the Eligible Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, continuation coverage for persons who lose coverage other than the Eligible Employee lasts until 36 months after the date of Medicare entitlement. For example, if an Eligible Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, 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).

Extension for Disability. Coverage may be extended beyond an initial eighteen (18) months based on disability. If the initial Qualifying Event was termination of employment or reduction of hours, and a person who has elected continuation coverage is determined – within the first eighteen (18) months of continuation coverage – to have been disabled under Social Security rules at any time during the first sixty (60) days of continuation coverage, that person and covered family members may obtain an additional eleven (11) months of coverage, at one hundred fifty per cent (150%) of the regular cost of coverage. The Plan Administrator must be notified within 60 days of the disability determination. This notice must be provided in writing to Delaware County Government, Human Resource Department, 100 W. Main Street, Room 208, Muncie, IN 47305 must be accompanied by written documentation proving that such an event has occurred and must be accompanied by the written determination of the Social Security Administration. If the disabled person is determined thereafter to be no longer disabled, the Plan Administrator must be notified within thirty (30) days, and the additional period of coverage will end.

End of Continuation Coverage. Continuation of coverage will end upon the earliest of the following dates:

1. The end of the applicable 18-month, 29-month, or 36-month period;
2. If the Qualifying Event was a military leave of absence, the day after the date on which the Eligible Employee fails to apply for or return to a position of employment with the Company.
3. The end of the period for which premiums have been paid if a subsequent premium is not paid;
4. The date the Company no longer sponsors this Plan or another Employee Benefit Plan;
5. The date the Covered Person first becomes entitled to Medicare benefits; or
6. The date the Covered Person first becomes covered under any other Employee Benefit Plan which does not have an exclusion or limitation on a Pre-Existing Condition of the Covered Person.

COORDINATION WITH MEDICARE

Secondary Coverage to Medicare. To the greatest extent allowable under applicable law, coverage under the Plan for a Covered Person who is also covered under Medicare shall be secondary to coverage of such Covered Person under Medicare. If a Covered Person's coverage under this Plan is secondary to his or her coverage under Medicare, the benefits payable under this Plan shall be reduced in the manner described in Section *Coordination with other Plans and Benefits*, Subsection *Effect on the Benefits of this Plan* (applying that Section by treating Medicare as an "Other Plan").

Primary Coverage to Medicare. If, in accordance with the above Subsection *Secondary Coverage to Medicare*, a Covered Person's coverage under this Plan is not permitted to be secondary to his or her coverage under Medicare, that Covered Person shall be reimbursed for Covered Charges in accordance with Section *Medical Benefits* of this Plan without regard to that Covered Person's coverage under Medicare.

Medicare Coverage Election. Notwithstanding any provision in this Section to the contrary, if a Covered Person is covered by Medicare and chooses not to be covered by this Plan, coverage under this Plan shall terminate.

Eligibility for Medicare. A Covered Person is considered covered under Medicare for the purposes of the Plan during any period such Covered Person has actual coverage under Medicare or, while otherwise qualifying for actual coverage under Medicare, does not have such coverage solely because he or she has refused or failed to make any necessary application for Medicare coverage.

COORDINATION WITH OTHER PLANS AND BENEFITS

Definitions. For purposes of this Section, the following terms shall have the following respective meanings:

(1) "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, which is covered (without regard to any applicable deductible or Coinsurance limit) at least in part by one or more plans covering the person for whom the claim is made.

(2) "Other Plan" means any of the plans, programs or policies listed below that provides benefits or services with respect to medical, dental, vision, prescription drug treatment, supplementary accident or weekly income:

(a) Group insurance or group-type coverage, whether insured or uninsured, including prepayment, group practice or individual practice coverage, but excluding school Accident-type coverage;

(b) Coverage under a governmental plan, required or provided by law, excluding any state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time) and any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program; and

(c) Coverage under any other individual insurance policy or arrangement that provides payment or reimbursement for medical, dental, vision, prescription drug supplementary accident, or weekly income expenses, including but not limited to, coverage under any automobile liability insurance policy (including no-fault coverage), any homeowners insurance policy, or any individual health insurance policy (including any policy issued by or through a state risk pool or similar arrangement).

Each contract or other arrangement for coverage under paragraphs (a), (b), or (c) shall be a separate Other Plan. If only part of a contract or other arrangement is subject to coordination of benefit rules, that part of such contract or other arrangement that is subject to coordination of benefit rules shall be treated as one Other Plan and the remainder of such contract or other arrangement shall be treated as a separate Other Plan.

(3) "Claim Determination Period" means, with respect to each person subject to this Section, a calendar year; provided, however, that a Claim Determination Period shall not include any part of a calendar year during which such person has no coverage under this Plan or any part of a calendar year before the date this Section or a similar coordination of benefits provision is effective with respect to such person.

Order of Benefit Determination Rules. With respect to a Covered Person who is covered under this Plan and an Other Plan described in the above Subsection *Definitions* (2)(c), this Plan shall be, in all instances, a secondary plan that has its benefits determined after those of the Other Plan. With respect to a Covered Person who is covered under this Plan and an Other Plan described in the above Subsection, *Definitions* (2)(a) or (b), this Plan shall be a secondary plan that has its benefits determined after those of the Other Plan, unless the Other Plan has rules coordinating its benefits with those of this Plan and both those rules and this Subsection, *Order of Benefit Determination Rules*, require that this Plan's benefits be determined before those of the Other Plan. For purposes of the preceding sentence, this Plan shall determine its order of benefits using the first of the following rules that applies:

(1) Eligible Employee/Dependent. The plan that covers the person as an Eligible Employee shall be primary and its benefits shall be determined before those of the plan that covers the person as a Dependent.

(2) Dependent Child/Parents Not Separated or Divorced. Except as otherwise provided in Subsection (c) below, when this Plan covers a child as the Dependent of one natural parent and an Other Plan covers the same child as a dependent of another natural parent:

(a) the plan covering the parent whose birthday falls earlier in a year shall be primary and its benefits shall be determined before those of the plan covering the parent whose birthday falls later in that year; provided, however, that

(b) if both parents have the same birthday, the Plan that covered a parent for a longer period of time shall be primary and its benefits shall be determined before those of the plan that covered the other parent for the shorter period of time; provided, further, that

(c) if the Other Plan does not apply the rule described in paragraphs (a) and (b) and instead applies the rule commonly known as the "gender rule," the rule of the plan that has covered a parent for the longer period of time shall be applied to determine the order of benefits.

(3) Dependent Child/Separated or Divorced Parents. If two or more plans cover as a dependent the natural child of divorced or separated parents, benefits for that child shall be determined in the following order:

(a) First, the plan covering the parent with custody of the child;
(b) Second, the plan covering the spouse of the parent with custody of the child;
(c) Third, the plan covering the parent not having custody of the child; and
(d) Fourth, the plan covering the spouse of the parent not having custody of the child;
(e) Fifth, if joint custody,
  (i) the plan covering the parent whose birthday falls earlier in a year; or
  (ii) if both parents have the same birthday, the Plan that covered a parent for a longer period of time; or
  (iii) if the Other Plan does not apply, the rule described in (i) and (ii) and instead applies the rule commonly known as the "gender rule," the rule of the plan that has covered a parent for the longer period of time shall be applied to determine the order of benefits.

provided, however, that, if a court order or court-approved settlement specifically provides that one of the parents is responsible for the health care expenses of the child and that parent's plan (or the plan administrator, trustee, or agent, Eligible Employee or designee of either) has actual knowledge of that court order or court-approved settlement, the benefits of the plan covering that parent shall be determined first; provided, further, that any benefits that are actually paid or provided before such plan (or the plan administrator, trustee, or agent, Eligible Employee or designee of either) has actual knowledge of that court order or court-approved settlement shall not be retroactively adjusted to reflect the preceding provision.

(1) Active/Inactive Eligible Employee. A plan that covers a person as an active Eligible Employee (or as that active Eligible Employee's dependent) shall be primary and its benefits shall be determined before those of a plan that covers that person as an inactive or retired Eligible Employee (or as that inactive or retired Eligible Employee's dependent). If an Other Plan does not apply the rule of this Subsection, and if, as a result, this Plan and that Other Plan do not agree on the order of benefits, this Subsection shall be ignored.

(5) Coordination with COBRA. The plan covering the individual as an Eligible Employee, or retiree, or as a dependent of an Eligible Employee will be primary, and the plan providing continuation coverage will be secondary. If the two plans do not have this rule and the plan COB rules disagree on the order of benefits, this rule would not apply.

(6) Longer/Shorter Length of Coverage. If none of the above Subsections of this Subsection, *Order of Benefit Determination Rules,* determines the order of benefits, the plan that covered a person for a longer period of time shall be primary and its benefits shall be determined before benefits are determined under the plan that covered that person for the shorter period of time.

Effect on the Benefits of this Plan. If, after application of the above Subsection *Order of Benefit Determination Rules*, this Plan is a secondary plan with respect to (and its benefits are determined after those of) one or more Other Plans, reimbursements for Covered Charges under this Plan shall be payable only in accordance with the formula set forth under the caption "Secondary Payor Rules" in Section *Medical Benefits.* For purposes of applying such formula, when an Other Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a benefit payable. When Covered Charges of this Plan are reduced in accordance with the preceding sentence, each separate Covered Charge shall be reduced in the same proportion and then charged against any applicable benefit limit of this Plan.

Right to Obtain and Provide Information. The applicable Plan Supervisor may obtain or provide (without the prior consent of, or notice to, any party) information that the applicable Plan Supervisor, in its sole discretion, determines if necessary or helpful with respect to the application of this Section. As a necessary condition to receiving benefits under this Plan, each Covered Person shall provide to the applicable Plan Supervisor any information the applicable Plan Supervisor requests.

Payment of Coordinated Benefits. If payment made under an Other Plan includes an amount that should have been paid under this Plan, the applicable Plan Supervisor may pay that amount directly to that Other Plan. Any amount paid under the preceding sentence shall be treated as a Covered Charge paid under this Plan, and such amount shall not be paid again. With respect to benefits provided in the form of services, the amount of a "payment made" shall equal the reasonable cash value of the benefits provided in the form of services.

Right of Recovery. If the amount of any payment made by the Plan is more than should have paid under the coordination of benefit rules of this Section, the Plan may recover the excess from:

(1) the Covered Person to whom, or on whose behalf, payment was made;
(2) any insurance company that should have made such payment;
(3) any Other Plan that should have made such payment;

(4) any service provider to whom such payment was erroneously made; or
(5) any other individual or entity which should have made such payment or which received the benefit of such erroneous payments.

With respect to benefits provided in the form of services, the amount of payments made shall equal the reasonable cash value of any benefits provided in the form of services.

FUNDING

Employer Contributions. This Plan shall share the cost of Eligible Employee and Dependent coverage under this Plan with the Eligible Employees.

Employee Contributions. The Plan Administrator sets the level of any Employee contributions. The required amount of contributions, if any, shall be communicated by the Company to the Eligible Employees and their Dependents. The Company hereby reserves the right to increase or decrease Eligible Employee or Dependent contributions from time to time. In the event that an Eligible Employee makes an overpayment of contributions due to a mistake in determining the eligibility of one or more of his family members, the Plan Administrator, in its sole discretion, shall determine whether a refund is appropriate and, if appropriate, the amount of the refund. For Eligible Employees and their Dependents, the enrollment application for coverage may include a payroll deduction authorization, if applicable. This authorization must be filled out, signed and returned with enrollment application.

Funding Mechanism. Benefits under this Plan will be paid from the Employer's general assets unless the Employer determines that the Employer and Eligible Employee contributions should be held in a trust, in which case the benefits will be paid from such trust.

ADMINISTRATION OF THE PLAN

Plan Administrator. Except as otherwise specifically provided in the Plan, in any insurance contract or in any trust document pursuant to which Plan benefits are funded, the Plan Administrator shall have the full, discretionary, and exclusive authority to control and manage the operation and administration of the Plan and shall be the named fiduciary of the Plan for purposes of the Act. The Plan Administrator shall have all power necessary or convenient to enable it to exercise such authority. In connection therewith, the Plan Administrator may provide rules and regulations, not inconsistent with the provisions hereof, for the operation and management of the Plan, and may from time to time amend or rescind such rules or regulations. The Plan Administrator may accept service of legal process for the Plan and shall have full discretionary power to take all actions necessary or proper to carry out the duties required under the Act, including, but not limited to, the power:

(1) To employ one (1) or more persons or entities to render advice with respect to any responsibility the Plan Administrator has under this Plan;
(2) To construe and interpret this Plan;
(3) To adopt such rules, regulations, forms and procedures as from time to time it deems advisable or appropriate in the proper administration of this Plan;
(4) To decide all questions of eligibility and to determine the amount, manner and time of payment of any benefits hereunder;
(5) To prescribe procedures to be followed by any person in applying for any benefits under this Plan and to designate the forms, documents, evidence or such other information as the Plan Administrator may reasonably deem necessary to support an application for any benefits under this Plan;
(6) To authorize, in its discretion, payments of benefits properly payable pursuant to the provisions of this Plan;
(7) To prepare and to distribute, in such manner as it deems appropriate, information explaining this Plan;
(8) To apply consistently and uniformly its rules, regulations, determinations and decisions to all Covered Persons in similar circumstances;
(9) To prepare and file such reports and to complete and to distribute such other documents as may be required to comply fully with the provisions of the Act, and of all regulations promulgated there under; and
(10) To retain counsel (who may, but need not, be counsel to the Company), to employ agents and to provide for such clerical, medical, accounting, auditing and other services as it may require in carrying out the provisions of this Plan.

Benefits under this Plan shall only be paid if the Plan Administrator decides, in its discretion, that the applicant (Covered Person) is entitled to them.

Delegation of Responsibility. The Plan Administrator may delegate duties involved in the administration of this Plan to such person or persons whose services are deemed necessary or convenient. However, both the ultimate responsibility for the administration of this Plan and the authority to interpret this Plan shall remain with the Plan Administrator. The Company shall indemnify any Eligible Employee to whom duties are delegated by the Plan Administrator pursuant to this Subsection from and against any liability that such Eligible Employee may incur in the administration of this Plan, except for liabilities arising from the recklessness or willful misconduct of such Eligible Employee.

Plan Supervisor. The Plan Administrator, in its sole discretion, may from time to time appoint one or more Plan Supervisors to provide consulting services to the Company and the Plan Administrator in connection with the operation of the Plan and to perform such other functions and services (including the processing and payment of claims) as may be delegated to it by the Plan Administrator. Any Plan Supervisor shall be entitled to reasonable compensation for its services.

The duties and responsibilities delegated to the Plan Supervisors shall be reflected in the separate written agreements between the Plan Administrator and the Plan Supervisors. The Plan Administrator may remove a Plan Supervisor, subject to any notice or other requirements set forth in such separate written agreement. Upon its removal, a Plan Supervisor shall transfer to any successor Plan Supervisor (or to the Plan Administrator, in the absence of a successor Plan Supervisor) all Plan records or other documents in its possession, as requested by the Plan Administrator. A Plan Supervisor shall be entitled to reimbursement of all reasonable expenses (including copying charges) incurred in connection with the transfer of Plan records or other documents to a successor Plan Supervisor (or to the Plan Administrator, in the absence of a successor Plan Supervisor).

Claims Procedure. Upon receipt of proof satisfactory to the Plan Supervisor that a Covered Person has Incurred Covered Charges for which he is entitled to reimbursement covered under this Plan, the Plan shall reimburse such Covered Person for such Covered Charges pursuant to the claims review and appeals procedure set forth below.

(1) All claims for benefits under this Plan shall be submitted to the Plan Supervisor on forms furnished for that purpose, or otherwise approved, by the Plan Supervisor. **Such claim form, along with a billing statement or invoice of the Covered Charges must be submitted within twelve (12) months from the date of**

service. Failure to submit written proof of loss with respect to a claim for Covered Charges before the deadline for submission of claims shall invalidate that claim, unless the affected Covered Person demonstrates to the satisfaction of the Plan Administrator that it was not reasonably possible to furnish such proof within the required time and that proof was furnished as soon as was reasonably possible

(2) The Plan Supervisor may select a Physician to examine any Covered Person whose Injury or Illness is the basis of a claim. The costs of any medical examination required under this provision shall be paid by the Plan. The Plan Supervisor may also question the health care provider or other professional person who performs services or provides supplies that are the basis of a claim for reimbursement of Covered Charges.

Foreign Claims. In the event a Covered Person incurs an expense in a foreign country, the Covered Person shall be responsible for providing the following to the Plan Administrator before payment of any benefits due are payable:

(1) The claim form, provider invoice and any other documentation required to process the claim must be submitted in the English language.
(2) The charges for services rendered must be converted into dollars.
(3) A current conversion chart validating the conversion from the foreign country's currency into dollars.

Deadlines for Processing Claims. The Plan Administrator shall notify a claimant of the Plan's benefit determination in accordance with the following rules.

(a) Urgent care claims. In the case of a claim involving urgent care, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator shall notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of: (1) the Plan's receipt of the specified information, or (2) the end of the period afforded the claimant to provide the specified additional information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with Form of Claim Denial Section.

(b) Concurrent Care Decisions. If this Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments --

(1) Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Plan Administrator shall notify the claimant, in accordance with Form of Claim Denial Section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(2) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with Form of Claim Denial and appeal shall be governed by Appeal of Claim Denials.

(c) Other Claims. In the case of a claim not described in subsections (a) or (b) of this Section, the Plan Administrator shall notify the claimant of the Plan's benefit determination in accordance with the following rules.

(1) Pre-Service Claims. In the case of a pre-service claim, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the 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 afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (1) shall be made in accordance with Form of Claim Denial.

(2) Post-Service Claims. In the case of a post-service claim, the Plan Administrator shall notify the claimant, in accordance with Form of Claim Denial, of the Plan's adverse benefit determination, within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, 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 expects to render a decision. If such an extension is necessary due to a failure of the 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 afforded at least 45 days from receipt of the notice within which to provide the specified information.

Form of Claim Denials. Except as otherwise provided in this Section, the Plan Administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. The notification shall be set forth, in a manner calculated to be understood by the claimant –

(a) The specific reason or reasons for the adverse determination;

(b) Reference to the specific Plan provisions on which the determination is based;

(c) 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;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(e) 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; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

(f) If the adverse benefit determination is based on a medical necessity, 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, or a statement that such explanation will be provided free of charge upon request; or

(g) In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

In the case of an adverse benefit determination concerning a claim involving urgent care, the information described in this section may be provided to the claimant orally within the prescribed time frame, provided that a written or electronic notification in accordance with this section is furnished to the claimant not later than 3 days after the oral notification.

Appeal of Claim Denials. Each claimant shall be provided a reasonable opportunity for a full and fair review of a claim and adverse benefit determination in accordance with the following procedures –

(a) Claimants shall have 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(b) Claimants shall have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefit;

(c) Each claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(d) Any review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

(e) Any review shall not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(f) In deciding an appeal of any 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, 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;

(g) The Plan Administrator shall identify 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;

(h) The health care professional engaged for purposes of a consultation under subsection (f) shall be an individual who is neither an individual who has consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(i) In the case of a claim involving urgent care, there shall be an expedited review process pursuant to which –

(1) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(2) All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

Time Deadlines for Determinations on Appeal. The Plan Administrator shall notify a claimant of the Plan's benefit determination on review in accordance with the following rules.

(a) Urgent Care Claims. In the case of a claim involving urgent care, the Plan Administrator shall notify the claimant, in accordance with Form of Notice of Determination on Appeal, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the Plan.

(b) Pre-Service Claims. In the case of a pre-service claim, the Plan Administrator shall notify the claimant, in accordance with Form of Notice of Determination on Appeal Section, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than 15 days after receipt by the Plan of the claimant's request for review of the adverse determination.

(c) Post-Service Claims. In the case of a post-service claim, the Plan Administrator shall notify the claimant, in accordance with Form of Notice of Determination on Appeal, of the Plan's benefit determination on review within a reasonable period of time. Such notification shall be provided not later than 30 days after receipt of the Plan of the Claimant's request for review of the adverse determination.

Form of Notice of Determination on Appeal. The Plan Administrator shall provide a claimant with written or electronic notification of a Plan's benefit determination on review. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant –

(a) The specific reason or reasons for the adverse determination;

(b) Reference to the specific Plan provisions on which the benefit determination is based;

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

(d) A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures and a statement of the claimant's right to bring an action under section 502(a) of the Act.;

(e) 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; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or their similar criterion will be provided free of charge to the claimant upon request;

(f) If the adverse benefit determination is based on a medical necessity, 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, or a statement that such explanation will be provided free of charge upon request; and

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

Additional Rules. In the case of a failure by a claimant or his authorized representative to follow the Plan's procedures for filing a "pre-service claim," the claimant or his representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a "claim involving urgent care") following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

This Section shall apply only in the case of a failure that

(a) Is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(b) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

Calculation of Time Limits. For purposes of this section, the period of time within which a benefit determination or review of a benefit determination is required to be made shall begin at the time a claim (or appeal, as the case may be) is filed in accordance with this Plan's procedures, without a regard to whether all the information necessary to make benefit determination (or review of a benefit determination) accompanies the filing. In the event that a period of time is extended as permitted under the Plan due to a claimant's failure to submit information necessary to decide a claim (or appeal), the period for making the benefit determination (or review of a benefit determination) shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Definitions. The following terms shall have the following meaning whenever used in the context of the claims review and appeal procedures in this Plan:

(a) A "claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations –

(1) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or

(2) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Except as provided in the following sentence, whether a claim is a "claim involving urgent care" within the meaning of paragraph (1) is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care' within the meaning of this subsection (a) shall be treated as a "claim involving urgent care."

(b) The term "pre-service claim" means any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(c) The term "post-service claim" means any claim for a benefit that is not a pre-service claim.

(d) The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(e) The term "health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

(f) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;

(3) demonstrates that the Plan provisions have been consistently and uniformly applied with respect to similarly situated claimants; or

(4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Actions. No person may bring any action at law or in equity to recover benefits under the Plan:

(1) prior to a final determination under the claims review procedures,
(2) after the expiration on one (1) year from the date of the final determination.

Any determination made or action taken by the Plan Administrator pursuant to this Section shall be deemed to be conclusive with respect to any Covered Person or other individual to whom that determination or action relates, any such determination or action may be reversed by a court of competent jurisdiction only upon a finding by the court that such determination or action was arbitrary and capricious.

ENTRY AND WITHDRAWAL OF EMPLOYERS

Entry Into Plan. With the consent of a duly authorized officer of the Company, any entity that is affiliated with the Company within the meaning of Section 414(b), (c) or (m) of the Code shall become an Employer as of that date approved by the Executive Director, or other duly authorized officer of the Company, and shall be subject to the terms and provisions of this Plan as then in effect and thereafter amended.

Withdrawal from the Plan. An Employer may withdraw from the Plan by delivering to the applicable Plan Supervisor written notice of its withdrawal no later than thirty (30) days prior to the date withdrawal is to be effective.

Addition or Deletion of Employers Upon the addition or deletion of Employers, the Plan Administrator shall instruct the applicable Plan Supervisor to make appropriate modifications to this Plan (including a statement as to the effective date of such addition or deletion) without the need for a Plan amendment.

SUBROGATION RIGHTS

If the Plan receives claims for expenses that were either the result of the alleged negligence of another person, or which arise out of any claim or cause of action which may accrue against any third party responsible for injury or death to the Covered Employee or Dependent of the Covered Employee (hereinafter named the Covered Person), the Plan has no duty or obligation to pay these claims.

The Plan may choose to advance benefits. If the Plan advances benefits, the Covered Person, by accepting benefits agrees to the following terms and conditions. If the Plan chooses to advance expenses, it is doing so only because, and in reliance upon, the Covered Person's promise to abide by the terms and conditions of the Plan and the Agreement the Plan requires the Covered Person to sign.

The Covered Person agrees that the Plan will be reimbursed first out of any recovery by the Covered Person for all injury-related benefits paid by the Plan. The Covered Person agrees that the Plan has a secured proprietary interest in any settlement proceeds that the Covered Person receives or may have an entitlement to receive. The Covered Person confesses that the Plan is entitled to a constructive trust interest in the proceeds of any settlement or recovery. The Covered Person consents to the imposition of said trust, the funding of said constructive trust using any settlement proceeds and the payment of said funds held in said trust directly to the Plan or its authorized representative. The Plan will be reimbursed in full prior to the Covered Person receiving any monies recovered from any party or their insurer as a result of judgment settlement or otherwise. The duty and obligation to reimburse the Plan also applies to any money received from any underinsured or uninsured motorist policy of insurance or any medical payment insurance or personal injury protection coverage. The obligation to repay the Plan remains in force even if the Covered Person is not fully compensated or made-whole from any settlement or verdict or judgment.

The Plan has the right to the Covered Person's full cooperation in any matter involving the alleged negligence of a third party. The Covered Person will also cooperate with the Plan relative to the Plan's attempts to collect from any medical payment insurance or personal injury protection coverage. In such cases, the Covered Person is obligated to provide the Plan with whatever information, assistance, and records the Plan may require to enforce the rights in this provision. The Covered Person further agrees that the Plan requires the Covered Person to complete a subrogation questionnaire, sign an acknowledgment of the Plan's Subrogation rights and sign an Agreement before the Plan considers paying, or continuing to pay, any claims. If the Covered Person fails or refuses to sign the Agreement, the Plan has no duty to pay any and all claims incurred by the Covered Person. If the Covered Person is represented by an attorney, the attorney must also sign the Agreement. Failure by the attorney to sign the Agreement will result in the Plan denying payment of the Covered Person's claims. This Agreement must be returned to the Plan within 30 days of receipt by the Covered Person or the Plan will deny payment of all benefits incurred between the date of injury and the receipt of this Agreement. Upon receipt of the requested materials from the Covered Person, the Plan may commence or may continue advancing claims payments according to its terms and conditions provided that said payment of claims in no way prejudices the Plan's rights to recovery.

The Covered Person agrees to include the Plan's name as a co-payee on any settlement check or check from any other party or insurer. The Covered Person specifically agrees to instruct any and all insurance companies who may issue any type of settlement check to place the Plan's name on the settlement check or in the alternative to issue a separate settlement check directly to the Plan.

The Plan may, but is not obligated to, take any legal action it sees fit against the third party or the Covered Person, to recover the benefits the Plan has paid. The Plan's exercise of this right will not affect the Covered Person's right to pursue other forms of recovery, unless the Covered Person and his legal representative consent otherwise. This includes a right of subrogation under which the Plan may file its own independent suit to collect its expenses from any applicable insurance policy.

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

The Plan specifically states that it has no duty or obligation to pay a fee to the Covered Person's attorney for the attorney's services in making any recovery on behalf of the Covered Person. The Covered Person consents to this provision and by accepting any advance of benefits agrees to instruct their attorney to not assess any fees against the Plan in the event of settlement or recovery.

The Covered Person is obligated to inform their attorney of the subrogation lien and to make no distributions from any settlement or judgment which will in any way result in the Plan receiving less than the full amount of its lien without the written approval of the Plan. The Covered Person agrees that they will instruct their attorney to reimburse the Plan out of any sums the attorney holds or may hold in his trust account.

The Covered Person agrees that they will not release any party or their insured without prior written approval from the Plan, and will take no action which prejudices the Plan's rights.

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

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

The Covered Person agrees that the Plan's right to receive its expenditures from any settlement is an equitable right under ERISA. In the event that the Covered Person fails to abide by the terms and conditions of this provision, the Covered Person agrees to the following:

1. The Plan may discontinue paying for ongoing claims until the Plan has refrained from paying an amount of claims equivalent to the Plan's lien.

2. The Plan may sue the Covered Person in state or federal court to receive reimbursement. The Covered Person agrees to pay the Plan's attorney fees associated with bringing said suit.

3. The Covered Person consents to the imposition of a temporary injunction restraining the Covered Person from spending, dissipating or transferring ownership in any settlement proceeds. The Covered Person also agrees to hold such proceeds in a separate account pending any order from the Court.

4. If the Covered Person receives a settlement and refuses to repay the Plan, the Covered Person understands that they have unlawfully converted the assets of an employee benefit plan and that they are subject to the statutory penalties for such conversion under either state or federal law.

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

In the event that the Covered Person receives any form or type of settlement and either fails or refuses to abide by the terms of this agreement, in addition to any other remedies the Plan may have, the Plan retains a right of equitable offset against future claims.

MICHIGAN ACCIDENTS

In the case of a Michigan insured who is covered by Michigan No-Fault coverage, the Plan will not pay claims until and unless all of the Michigan No-Fault coverage is exhausted first.

HIPAA PRIVACY & SECURITY REGULATIONS

Use and Disclosure of Protected Health Information

Except as provided under Section 2(b) or (c) of this Amendment or as otherwise authorized under a valid Authorization, this Plan, in order to disclose Protected Health Information to the Employer or to provide for or permit the disclosure of Protected Health Information to the Employer by a health insurance issuer or HMO with respect to the Plan, shall restrict uses and disclosures of such information by the Employer consistent with the requirements set forth in this Amendment.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose Summary Health Information to the Employer, if the Employer requests the Summary Health Information for the purpose of:

obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose to the Employer information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

This Plan may:

disclose Protected Health Information to the Employer to carry out Plan Administration Functions that the Employer performs only to the extent consistent with the provisions of this Amendment;

not permit a health insurance issuer or HMO with respect to the Plan to disclose Protected Health Information to the Employer except as permitted by this Amendment;

not disclose and may not permit a health insurance issuer or HMO to disclose Protected Health Information to the Employer as otherwise permitted by this Amendment unless a statement to that effect is included in the appropriate notice of privacy practices; and

not disclose Protected Health Information to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

Employer Certification

This Plan will disclose Protected Health Information to the Employer only upon receipt of a certification by the Employer that the Plan documents have been amended to incorporate the provisions of this Section. With respect to Protected Health Information disclosed to the Employer by the Plan, the Employer agrees to:

not use or further disclose the information other than as permitted to required by the Plan documents or as required by law;

ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;

not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

make available Protected Health Information in accordance with 45 CFR § 164.524;

make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR §164.526;

make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with this Amendment;

if feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form and retain no copies of such information 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 information infeasible; and

ensure that the adequate separation required in Section 4 of this Amendment is established.

Separation Between Plan and Employer

A list of those employees or classes of employees or other persons under the control of the Employer who are permitted to have access to the Protected Health Information to be disclosed is made available on the Company web site and will be updated as necessary. Any employee or person who receives Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business shall be deemed to have been included in such list.

access to and use by such employees and other persons described in Section 4(a) of this Amendment shall be restricted to the Plan Administration Functions that the Employer performs for the Plan.

The Plan Administrator shall investigate any allegations by a participant, beneficiary or other person of a breach of the Employer's or Plan's obligations under this Amendment. If the Plan Administrator determines there has been such a breach, the Plan Administrator shall provide a summary report of such breach, identifying the person responsible for such breach, to the Employer. If the person responsible for the breach is an employee of the Employer, the Employer shall take such disciplinary action against that person as required under the Employer's employment policies and practices.

Definitions

For purposes of this Amendment, the following capitalized terms shall have the following meanings:

"Authorization" means an authorization by an individual that permits the Plan to use or disclose Protected Health Information that complies with the requirements of 45 CRF §164.508(c).

"HIPAA" means the security and privacy requirements applicable to health plans as reflected in 42 U.S.C. 1320d *et seq.* and such regulations as may be promulgated thereunder from time to time (currently, 45 CFR §164.102 through §164.534).

"Plan Administration Functions" means administration functions performed by the Employer on behalf of the Plan and excludes functions performed by the Employer in connection with any of its other benefits or benefit plans.

"Protected Health Information" means individually identifiable health information of the Plan that is (i) transmitted by electronic media, (ii) maintained in any medium described as electronic media, or (iii) transmitted or maintained in any other form or medium. "Protected Health Information" does not include individually identifiable health information in: (i) education records covered by the Family Educational Right and Privacy Act (20 U.S.C. section 1232g(a)(4)(B)(iv)), or (ii) records described at 20 U.S.C. section 1232g(a)(4)(B)(iv).

"Summary Health Information" means information, that may be individually identifiable health information, and:

that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Employer has provided health benefits under this Plan; and

from which the following information has been deleted:

names;

all geographic subdivisions smaller than a State, including street address, city, county precinct, zip code, and their equivalent geocodes, except for the initial five digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(1) The geographic unit formed by combining all zip codes with the same five initial digits contains more than 20,000 people; and

(2) The initial five digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

all elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

telephone numbers;

fax numbers;

electronic mail addresses;

social security numbers;

medical record numbers;

health plan beneficiary numbers;

account numbers;

certificate/license numbers;

vehicle identifiers and serial numbers, including license plate number;

device identifiers and serial numbers;

Web Universal Resource Locators (URLs);

Internet Protocol (IP) address numbers;

biometric identifiers, including finger and voice prints;

full face photographic images and any comparable images; and

any other unique identifying number, characteristic, or code, except a code or other means of de-identifying and re-identifying information permitted under HIPAA.

AMENDMENT AND TERMINATION OF PLAN

Plan Amendment. A duly authorized officer of the Company shall have the right, in his or her sole discretion, to amend or modify the Plan at any time and from time to time and to any extent deemed advisable, subject to the terms and conditions of any applicable collective bargaining agreement. Such modification or amendment shall be in writing and shall be effective as of the date indicated in such written amendment or modification.

Plan Termination. All or any part of this Plan may be terminated at any time by the Executive Director (or any duly authorized officer) of the Company, except to the extent otherwise prohibited under the terms of a collective bargaining agreement. In the event of such termination, the Employers' sole obligation under the Plan shall be to pay the Covered Charges Incurred (even though later filed) and expenses of the Plan accrued through the date of termination. To the extent allowed by the Act, any such termination may be effective retroactively. Subrogation rights (as described in Section *Subrogation Rights*) shall also apply through the date of termination and applicable run-out payment periods.

MISCELLANEOUS PROVISIONS

Non-Alienation and Assignment. The Plan shall not be liable for any debt, liability, contract or tort of any Eligible Employee or Covered Person. The Plan shall pay all benefits due and payable for Covered Charges directly to the Covered Person who incurred the Covered Charges, and no Plan benefits shall be subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation or any other voluntary or involuntary alienation or other legal or equitable process not transferable by operation of law; provided, however, that a Covered Person to whom benefits are otherwise payable may assign benefits to a Hospital, Physician or other service provider; provided, further, that any such assignment of benefits by a Covered Person to a Hospital, Physician or other service provider shall be binding on the Plan only if:

(1) the Plan Administrator or applicable Plan Supervisor is notified of such assignment prior to payment of benefits;
(2) the assignment is made on a form provided by, or approved by, the applicable Plan Supervisor; and
(3) the assignment contains such additional terms and conditions as may be required from time to time by the Plan Administrator or applicable Plan Supervisor.

Fiduciary Responsibilities. No fiduciary of the Plan shall be liable for any act or omission in carrying out his or its responsibilities under the Plan, except as may be provided under the Act.

Allocation of Fiduciary Responsibilities. Each fiduciary under the Plan shall be responsible only for the specific duties assigned to it, him, or her under the Plan and shall not be directly or indirectly responsible for the duties assigned to another fiduciary, except as may be otherwise provided in the Act.

Headings. Any headings or subheadings in the Plan are for convenience and shall be ignored in the construction of any provisions of the Plan.

Choice of Law. The Plan shall be construed, enforced and administered in accordance with the laws of the State of Indiana or any other state in which this Plan shall be enforced, to the extent such laws are not preempted by the Act.

Limitation of Rights and Obligations. Neither the establishment, nor the maintenance of this Plan, nor any amendment thereof, nor the purchase of any insurance contract, nor any act or omission under this Plan or resulting from the operation of the Plan shall be construed:

(1) As conferring upon any Eligible Employee, beneficiary or any other person, a right or claim against an Employer or the Plan Administrator, except to the extent that such right of claim shall be specifically expressed and provided in the Plan;
(2) As creating any responsibility or liability of the Plan Administrator for the validity or effect of the Plan; or
(3) As a contract or agreement between any Employer and any Eligible Employee or to be consideration for, or as affecting in any manner or to any extent whatsoever, the rights or obligations of an Employer or any Eligible Employee to continue or terminate the employment relationship at any time. Nothing in the Plan shall be deemed to give any Eligible Employee the right to be retained in the service of any Employer, or to interfere with the right of any Employer to discharge any Eligible Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements between any Employer and the bargaining representatives of any Eligible Employee.

Facility of Payment. If, in the opinion of the applicable Plan Supervisor, a valid release cannot be obtained from a Covered Person with respect to the payment of any Plan benefit, such payment may be made directly to a Hospital, Physician or other service provider; the Covered Person's guardian, conservator or estate; the parents of a minor child or an individual or individuals who have custody or provide care and principal support of the Covered Person. Any payment made by the applicable Plan Supervisor in good faith pursuant to this Subsection shall fully discharge all Plan liability to the extent of such payment.

Employment of Consultants. The Plan Administrator, or a fiduciary named by the Plan Administrator pursuant to the Plan, may employ one or more persons to render advice with regard to its respective responsibilities under the Plan.

Notice. Any notice given under this Plan shall be sufficient if:

(1) to the Plan Administrator when addressed to it at its office;
(2) to the applicable Plan Supervisor when addressed to it at its office or;

(3) to a Covered Person when addressed to the Covered Person at his or her address as it appears on the records of the applicable Plan Supervisor.

Misrepresentation. Any material misrepresentation on the part of the Covered Person in applying for coverage, in applying for a reclassification to an Eligible Class or in filing a claim for benefits shall render the Covered Person's coverage null and void.

Disclaimer of Liability. Nothing contained herein shall confer upon a Covered Person any claim, right or cause of action, either at law or at equity, against the Plan, Plan Administrator, applicable Plan Supervisor, Company or any Employer for the acts or omissions of any health care provider from whom a Covered Person receives care, or for the acts or omissions of any Physician from whom the Covered Person receives service under this Plan, or for any acts or omissions of any provider of services or supplies under this Plan.

Certification of Prior Health Care Coverage. The Plan Administrator, or its designee, will provide to Covered Persons certification of their coverage under this Plan as required by the Health Insurance Portability and Accountability Act of 1996.

Entire Plan. This Plan Document and Summary Plan Description shall constitute the only legally governing document for the Plan. All statements made by the Company, Plan Administrator or applicable Plan Supervisor shall be deemed representations and not warranties. No such statement shall void or reduce coverage under this Plan or be used in defense to a claim unless in writing signed by the Plan Administrator or applicable Plan Supervisor.

Construction. In the construction of this Plan, the masculine includes the feminine, the feminine includes the masculine, and the singular includes the plural where appropriate.

Non Guarantee of Tax Consequences. Neither the Plan Supervisor, the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid under this Plan will be excludible from income for federal or state income tax purposes.

Genetic Information Nondiscrimination Act of 2008. This Plan shall comply with the Genetic Information Nondiscrimination Act of 2008 (GINA), as amended, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing the Plan. As part of such compliance, the Plan may not adjust premium or contribution amounts for the group covered under the Plan on the basis of genetic information and shall not request or require an individual or a family member of such individual to undergo a genetic test. The Plan also shall not request, require, or purchase genetic information for underwriting purposes or with respect to any individual prior to such individual's enrollment under the Plan in connection with such enrollment.

DEFINITIONS

Accident. The term "Accident" means a sudden, unforeseen and unintended event arising from an external cause.

Act. The term "Act" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

Actively at Work or Active Work. The term "Actively at Work" or "Active Work" means, that, on the day that coverage's under the Plan would begin, an Eligible Employee is not absent from work due to an unapproved absence, which is not related to the health of the Eligible Employee.

Ambulatory Surgical Center. The term "Ambulatory Surgical Center" means a surgical facility licensed as an ambulatory surgical center under the laws of the state at the time and place Covered Charges are Incurred.

Ancillary Charges. Charges for Hospital services that are exclusive of such routine services as room and board and nursing. Examples of Ancillary Charges include X-rays and laboratory charges.

Annual Out-of-Pocket Maximum. The Maximum yearly amount of Covered Charges (excluding Copayments, Cost Containment Penalties and Deductibles) that a Covered Person will pay through Coinsurance. Once this Maximum is met, the Plan will pay 100% of Covered Charges for the remainder of the year.

Birthing Center. The term "Birthing Center" means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year. The term "Calendar Year" means January 1st through December 31st of the same year.

COBRA. The term "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code. The term "Code" means the Internal Revenue Code of 1986, as amended from time to time.

Coinsurance. The term "Coinsurance" means with respect to a Covered Person the percentage of Covered Charges for which he or she is financially responsible and which shall not otherwise be payable under the terms of the Plan; provided, however, any such Coinsurance shall be determined after any Deductible amount is applied. The Coinsurance percentage is specified in the *Benefit and Information Grid* Section.

Copayment. An amount of money that is paid each time a particular service is used. Copayments do not accrue towards the Out-of-Pocket Maximum.

Cosmetic Surgery. The term "Cosmetic Surgery" means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements.

Covered Charges. The term "Covered Charges" means with respect to a Covered Person the Usual & Customary Charges for those Covered Services that are:

(1) specified in Section *Covered Services*;
(2) Medically Necessary for the care and treatment of an Injury or Illness and recommended by a Physician;
(3) incurred while that Covered Person is covered under this Plan; and
(4) covered charges include any taxes or surcharges imposed by a governmental entity based on the value or volume of Covered Services provided to Covered Persons, or amount imposed or assessed against the Plan or the Employer in lieu of such taxes or surcharges.

Covered Person. The term "Covered Person" means each Eligible Employee or Dependent who is covered under the Plan as set forth in Section *Eligibility, Enrollment, and Termination of Coverage.*

Creditable Coverage. The term "Creditable Coverage" means those periods of coverage required to be included as such under 701(c) of ERISA and shall exclude those periods of coverage permitted to be excluded under Section 701(c) of ERISA. Solely

for purposes of illustration and not in limitation of the foregoing, Creditable Coverage generally includes periods of coverage under an individual or Employee Benefit Plan (including Medicare, Medicaid, governmental, and church plans) that are not followed by a period of at least 63 days without coverage (not including any applicable waiting period), and Creditable Coverage generally excludes periods of coverage for liability, limited scope dental or vision benefits, specific disease and/or other supplemental-type benefits.

Custodial Care. The term "Custodial Care" means personal care that does not require the continuing attention of trained medical or paramedical personnel and that serves to assist an individual in the activities of daily living. Custodial Care includes, but shall not be limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that can usually be self-administered.

Deductible. The term "Deductible" means with respect to a Covered Person the amount of Covered Charges for which he or she is financially responsible each calendar year before benefits are payable under this Plan. The amount of the Deductible for each Covered Person is specified in the *Benefit and Information Grid* Section.

Dentist. The term "Dentist" is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent. The term "Dependent" means the spouse of an Eligible Employee (other than a spouse who is legally separated from the Eligible Employee under state law) and each child of an Eligible Employee who is described in Section *Eligibility, Enrollment, and Termination of Coverage* under the Subsection *Eligible Dependent Children*; provided, however, that no person who is a full-time member of the armed forces shall be considered a Dependent.

In determining whether an individual is a Dependent, in the case of a child who would otherwise be a Dependent under this Plan and whose parents agree, pursuant to a court order or divorce decree, which parent is responsible for the medical care of such child, such child shall be a Dependent only if the agreed upon responsible parent is an Eligible Employee; provided, however, that a child shall also be a Dependent of an Eligible Employee, regardless of agreement of the parents, to the extent provided by a qualified medical child support order issued under Section 609 of the Act.

Effective Date. The term "Effective Date" most often means the date that coverage becomes effective for the Covered Person. It can also mean the Effective Date for this restatement which is August 1, 2010.

Eligible Class. The term "Eligible Class" means each employment classification of Eligible Employees eligible to participate in the Plan as set forth in Section *Eligibility, Enrollment, and Termination of Coverage*.

Eligible Employee. The term "Eligible Employee" means an Eligible Employee of the Employer who is meets the requirements listed in Section *Eligibility, Enrollment, and Termination of Coverage*.

Emergency. The term "Emergency" means the following:

1) **Accident:** A sudden and unforeseen event which includes all of the following:
   a) causes injury to the physical structure of the body;
   b) results from an external agent or trauma;
   c) is definite as to time and place; and
   d) happens involuntarily, or if it is the result of a voluntary act, entails unforeseen consequences.
2) **Emergency Illness:** A medical condition that is not accident related and that is characterized by the sudden onset of acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in any of the following:
   a) permanently placing the participant's health in jeopardy;
   b) causing other serious medical consequences;
   c) causing serious impairment of bodily function; or
   d) causing serious and permanent dysfunction of any bodily organ or part.

Employer. The term "Employer" means the Company and any entity that is affiliated with the Company within the meaning of Section 414(b), (c) or (m) of the Code, that adopts this Plan for the benefit of its Eligible Employees, whose participation in the Plan is approved by the Executive Director (or any other duly authorized officer) of the Company.

Employment Termination Date. The term "Employment Termination Date" means, with respect to a particular Eligible Employee, the date that Eligible Employee's employment with an Employer is voluntarily or involuntarily terminated.

Enrollment Date. The term "Enrollment Date" means the date on which a Covered Person becomes covered under the Plan or, if earlier and applicable, the first day of the Waiting Period.

ERISA. The term "ERISA" is the Employee Retirement Income Security Act of 1974 as amended.

Experimental and/or Investigational. The term "Experimental and/or Investigational" means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan Administrator will be guided by the following principles:

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

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

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

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

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

Extended Care Facility. The term "Extended Care Facility" means an institution, or a distinct part of an institution, which is licensed to provide Inpatient care to persons convalescing from Injury or Illness including, but not limited to:

(1) Professional nursing services rendered by a Registered Nurse (RN) or by a Licensed Practical Nurse (LPN);

(2) Physical restoration services assisting patients in reaching a degree of bodily function permitting self-care in essential daily living activities;

(3) Providing 24 hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse; or

(4) Maintaining a complete medical record on each patient.

The term Extended Care Facility shall not include a place that provides, other than incidentally, for: rest, the aged, drug addicts, alcoholics, mentally handicapped, custodial or educational care, or care of mental disorders.

Family Unit. The term "Family Unit" means an Eligible Employee and his or her Dependents.

Full-Time Eligible Employees. The term "Full-Time Eligible Employees" is as defined in the salary ordinance of Delaware County Government.

Generic Drug. The term "Generic Drug" means a Prescription Drug, which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information. The term "Genetic Information" means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Home Health Care. The term "Home Health Care: means services and supplies provided to a Covered Person in his home by a Home Health Care Agency as an alternative to Hospital Confinement, provided that such services and supplies are recommended by a Physician.

Home Health Care Agency. The term "Home Health Care Agency" means an institution which is operated primarily for the purpose of providing skilled nursing care and therapeutic services in a person's home, provided that the Home Health Care Agency is approved and licensed by a state licensing agency and meets the requirements of the Social Security Amendments of 1965, as amended.

Hospice. The term "Hospice" means a free-standing or Hospital affiliated facility which provides short periods of stay for the terminally ill (i.e., individuals with life expectancies of less than six (6) months) in a home-like setting for either direct care or respite. The facility must operate as an integral part of a formal Hospice Care Program directed by a Physician for the purpose of caring for a terminally ill person. The Hospice Care Program must meet the standards set by the National Hospice Organization and be approved by the Plan Supervisor. If the Hospice Care Program is required by a state to be licensed, certified or registered, the Program must also meet that requirement to be considered an eligible Hospice Care Program.

Hospital. The term "Hospital" means an institution that is licensed as a hospital under the laws of the state at the time and place Covered Charges are Incurred; and is accredited by the Joint Commission on Accreditation of Hospitals or by the American Osteopathic Association; provided, however, that the term "Hospital" shall not include an institution that is primarily a nursing home or a place for rest for the aged, drug addicts, alcoholics, treatment of tuberculosis or mental disorders.

Hospital Confinement. The term "Hospital Confinement" means the period of time during which a person is an inpatient at a Hospital.

Human Growth Hormone. The term "Human Growth Hormone" means an adenohypophyseal hormone that promotes growth and also has direct influence on the metabolism of carbohydrates, fats, and proteins.

Illness. The term "Illness" means a sickness or disease that requires treatment by a Physician, is sustained by a Covered Person while covered under this Plan and is not due to an Injury.

Immediate Family. The term "Immediate Family" is defined as parents, step-parents, siblings, spouse, children, step-children, foster children, in-laws, grandparents, great grandparents, step-grandparents, step-great grandparents, grandchildren, step-grandchildren, aunts, uncles, nieces and nephews.

Incurred. The term "Incurred" means the date on which a service or supply was rendered or furnished, without regard to when a Covered Person is formally billed or charged, or pays for, the service or supply. In the absence of due proof to the contrary, when a single charge is made for a series of identical services, each service shall be considered to bear a pro rata share of the charge.

Injury. The term "Injury" means a physical or mental condition that is the direct or indirect result of an Accident (other than an occupational Accident).

Inpatient. The term "Inpatient" means a Covered Person who is admitted and registered to an inpatient bed in a Hospital and for whom a room and board charge is Incurred.

Intensive Care Unit. The term "Intensive Care Unit" is defined as a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit". It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Intensive Outpatient Program. **(IOP)** The term "Intensive Outpatient Program" is defined as an outpatient program that is operated according to the law, which provides a more intense level of treatment in a structured outpatient setting for patients who are seeking treatment for mental health or substance disorders. The program is designed to meet three to five times a week in a two to three hour time segment per meeting. The program must be operated or supervised by a licensed physician certified in

psychiatry by the American Board of Psychiatry and Neurology or Psychologist licensed in the state in which the services are rendered and operated according to the law. The program must be certified or licensed by the state Department of Health for treatment of Mental Disorders or Substance Abuse.

Late Enrollee. The term "Late Enrollee" means any Eligible Employee or Dependent who enrolls in the Plan after the initial eligibility period as described in Section *Eligibility, Enrollment, and Termination of Coverage*, Subsection *Individual Enrollment and Effective Dates*, herein. However, a Special Enrollee shall not be considered a Late Enrollee.

Lifetime. The term "Lifetime" references benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medically Necessary. The term "Medically Necessary" means, with respect to health care services or supplies, those services or supplies that are essential to the care and treatment of an Illness or Injury and that could not have been omitted without adversely affecting the patient's medical condition or the quality of the health care rendered under generally accepted professional standards of medical practice at the time and place Incurred. Health care services to improve personal appearance are not considered Medically Necessary unless necessitated by an Injury.

Medical Emergency. The term "Medical Emergency" means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions. In addition, Medical Emergency includes a mental health or chemical dependency condition when the lack of medical treatment could reasonably be expected to result in the patient harming self and/or other persons.

Medicare. The term "Medicare" means Part A and Part B of Title XVIII of the Social Security Act, as amended from time to time.

Mental Illness/Disorder. The term "Mental Illness/Disorder" means any disease or condition that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity. The term "Morbid Obesity" is a diagnosed condition in which the body weight exceeds the medically recommended weight by 100 pounds.

Non-Residential Treatment Facility. The term "Non-Residential Treatment Facility" shall mean a facility that can provide medical and other services for the treatment of Substance Abuse to individuals who do not require inpatient status and are free from acute physical and mental complications. The facility must maintain an organized program of treatment which may be limited to less than twelve (12) hours per day and not be available seven (7) days a week. The facility must be certified or licensed by the state Department of Health for treatment of Mental Disorders or Substance Abuse.

No-Fault Auto Insurance. The term "No-Fault Auto Insurance" is the basic reparation provision of a law providing for payments without determining fault in connection with automobile accidents.

Orthopedic Device. The term "Orthopedic Device" means any device used for the prevention or correction of disorder involving locomotor structures of the body, especially the skeleton, joints, muscles, fascia, and other supporting structures as ligaments and cartilage.

Orthotic Device. The term "Orthotic Device" means any device added to the body to stabilize or immobilize a body part, prevent deformity, protect against injury, or assist with functions.

Outpatient. The term "Outpatient" means a Covered Person who receives medical care, treatment, services or supplies while not registered as an Inpatient.

Partial Hospitalization. The term "Partial Hospitalization" is an outpatient program specifically designed for the diagnosis or active treatment of a serious mental disorder where there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse. This program shall be administered in a psychiatric facility, which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours a day and no charge is made for room and board.

Pharmacy. The term "Pharmacy" means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician. The term "Physician" means a doctor of medicine or doctor of osteopathy who is legally qualified and licensed to practice medicine, surgery or obstetrics at the time and place a service is Incurred with respect to a Covered Person, other than an individual who ordinarily resides in that Covered Person's home, or who is a member of the Immediate Family.

Plan. The term "Plan" means the plan as embodied herein, including all Sections attached hereto, as amended from time to time.

Plan Administrator. The term "Plan Administrator" means the Company. The Plan Administrator shall be the named fiduciary under the Plan.

Plan Supervisor. The term "Plan Supervisor" means Unified Group Services, Inc., the applicable third party administrator of any benefits provided under this Plan, or any successor as may be appointed from time to time by the Plan Administrator under Section *Administration of the Plan*, Subsection *Plan Supervisor* of this Plan.

Plan Year. The term "Plan Year" is the 12-month period beginning on August 1 and ending on July 31 of each year.

Pre-Existing Condition. The term "Pre-Existing Condition" means a physical or mental condition of a Covered Person, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the Enrollment Date. Genetic status information is not treated as a Pre-Existing Condition in the absence of a diagnosis of a condition related to such information. Pregnancy shall not be treated as a Pre-Existing Condition under the Plan. The length of a Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has creditable coverage from another health plan.

Pregnancy. The term "Pregnancy" is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug. The term "Prescription Drug" means any of the following: a drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription.

Primary Care Physician. The term "Primary Care Physician" means any Physician of medicine who is legally qualified to practice medicine at the time and place a service is Incurred with respect to a Covered Person, other than an individual who ordinarily resides in the Covered Person's home, or who is the spouse, child or parent of that Covered Person, and is a General Practitioner, Family Practitioner, Pediatrician, or a General Internist whose practice is at least 70% General Medicine. Covered Persons are strongly encouraged to select and utilize a Primary Care Physician but no penalty applies if this guideline is not followed.

Prosthetic Device. The term "Prosthetic Device" means any device used to replace missing or non-functional body parts.

Psychiatric Day Treatment Facility. The term "Psychiatric Day Treatment Facility" means a public or private facility, licensed and operated according to the law, which provides: treatment for all its patients for not more than eight (8) hours in any 24-hour period; a structured psychiatric program based on an individualized treatment plan that includes specific attainable goals and objectives appropriate for the patient; and supervision by a physician certified in psychiatry by the American Board of Psychiatry and Neurology. The facility must be accredited by the Program for Psychiatric Facilities or the Joint Commission on Accreditation of Hospitals.

Psychiatrist. The term "Psychiatrist" means a person who is legally qualified and licensed to practice psychiatry at the time and place services are rendered to a Covered Person, other than an individual who ordinarily resides in that Covered Person's home, or who is a member of the Immediate Family.

Psychologist. The term "Psychologist" means a person who is legally qualified and licensed to practice psychology at the time and place services are rendered to a Covered Person, other than an individual who ordinarily resides in that Covered Person's home, or who is a member of the Immediate Family.

Reconstructive Surgery. The term "Reconstructive Surgery" is a procedure performed to restore the anatomy and/or functions of the body, which are lost or impaired due to an Injury or Illness.

Regular Enrollee. The term "Regular Enrollee" means an Eligible Employee or Dependent who enrolls in the Plan other than through special or late enrollment as described in Section *Eligibility, Enrollment, and Termination Coverage*, Subsection *Individual Enrollment and Effective Dates.*

Regularly Scheduled Hours. The term "Regularly Scheduled Hours" is defined as the normal scheduled hours of the location, at which the Eligible Employee works and is not based on the department or position in which the Eligible Employee works.

Rehabilitation Facility. The term "Rehabilitation Facility" means a legally operating institution or distinct part of an institution which has a transfer agreement with one or more hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services.

It does not include institutions which provide only minimal care, custodial care, ambulatory or part-time care services, or an institution which primarily provides treatment of mental/nervous disorders, substance abuse or tuberculosis, except if such facility is licensed, certified or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Residential Treatment Facility. The term "Residential Treatment Facility" means a child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents. The facility must be accredited as a residential treatment facility by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals or the American Association of Psychiatric Services for Children.

Sickness. The term "Sickness" is a person's illness, disease or Pregnancy (including complications).

Skilled Nursing Facility. The term "Skilled Nursing Facility" means an institution, or distinct part of an institution, which

(1) is primarily engaged in providing to residents

  (a) skilled nursing care and related services for residents who require medical or nursing care, or
  (b) rehabilitation services for the rehabilitation of injured, disabled, or ill persons, and is not primarily for the care and treatment of mental diseases;

(2) has in effect a transfer agreement with at least one (1) Hospital; and
(3) meets the requirements for a Skilled Nursing Facility as described in Title XVIII of the Social Security Act, as amended.

Special Enrollee. The term "Special Enrollee" means an Eligible Employee or Dependent who is entitled to and does request special enrollment as described in Section *Eligibility, Enrollment, and Termination of Coverage*, Subsection *Special Enrollment.*

Spinal Manipulation/Chiropractic Care. The term "Spinal Manipulation/Chiropractic Care" means skeletal adjustments, manipulation, or other treatment in connection the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse. The term "Substance Abuse" is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that result in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Summary Plan Description. (SPD) The term "Summary Plan Description" shall also mean the Plan as defined in the above Subsection *Plan.*

Temporomandibular Joint. (TMJ) The term "TMJ" is the treatment of jaw joint problems including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled). The term "Total Disability" means in the case of an Active Eligible Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Illness.

Usual & Customary Charge. The term "Usual & Customary Charge" means the charge made by a Physician or supplier of services or supplies to the extent such charge does not exceed the general level of charges made by others rendering or furnishing such services or supplies within the same area in which the charge is Incurred for Illnesses or Injuries comparable in nature and

severity to the Illness or Injury being treated. The term "area" as it applies to any particular service or supply means a county or such greater area as is necessary to obtain a representative cross section of charges. If the Usual & Customary Charge for a service or supply cannot be easily determined because of the unusual nature of the service or supply, the determination shall be made by the applicable Plan Supervisor based on information it deems pertinent.

Waiting Period. The term "Waiting Period" means the period of time that the Eligible Employee must be employed prior to becoming eligible (and having any Dependents become eligible) for coverage under the Plan. The Waiting Period is counted in the Pre-existing Conditions exclusion time.

Delaware County Government has adopted this Delaware County Government Employee Benefit Plan as of the first day of August, 2010. I have read the document herein and certify that the contents reflect the terms and conditions of the Employee welfare benefit plan as established by Delaware County Government.

Executed on this 7 day of September, 2010.

Delaware County Government
"The Company"

By: _____

Printed Name: TODD DONATI

Title: President

Attested by:

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