SUMMARY PLAN DESCRIPTION FOR

TEACHERS

HEALTH AND WELFARE PLAN

NEW HAVEN, INDIANA
PREFACE

The East Allen County Schools HEALTH AND WELFARE PLAN, hereinafter called the Plan, defines the benefits that shall be paid to or on behalf of a Covered Person during the continuance of this Plan in the event they incur Eligible Expenses as defined herein. The Plan is subject to all the terms, provisions and limitations re-stated herein and shall become effective as of 12:01 a.m. Standard Time on September 1, 2011 at New Haven, IN

Plan Year:

The financial records of the Plan are kept on a calendar year basis ending on each August 31.

Employer Identification Number: 35-1097344

The Plan Identification Number assigned to this Plan for reports to U.S. Labor Department is: 501
TABLE OF CONTENTS

SECTION 1: SCHEDULE OF BENEFITS
SECTION 2: DEFINITIONS
SECTION 3: ELIGIBILITY, EFFECTIVE DATE AND TERMINATION
SECTION 4: MAJOR MEDICAL EXPENSE BENEFITS
SECTION 5: COVERED MAJOR MEDICAL EXPENSES
SECTION 6: PLAN EXCLUSIONS
SECTION 7: PLAN LIMITATIONS
SECTION 8: PRESCRIPTION DRUG PROGRAM
SECTION 9: DENTAL EXPENSE BENEFITS
SECTION 10: VISION BENEFITS
SECTION 11: COORDINATION OF BENEFITS
SECTION 12: UTILIZATION REVIEW
SECTION 13: LARGE CLAIM MANAGEMENT
SECTION 14: CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)
SECTION 15: THIRD PARTY RECOVERY PROVISION
SECTION 16: MISCELLANEOUS PROVISIONS
SECTION 17: CLAIM FILING AND APPEAL PROCEDURES
SECTION 18: GENERAL PROVISIONS/ERISA
SECTION 1. MEDICAL SCHEDULE OF BENEFITS

ELIGIBILITY/WAITING PERIOD

Coverage is effective the first day of employment in the eligible group.

MAJOR MEDICAL BENEFITS (Benefits Available If Elected)

Maximum Benefit (Lifetime Aggregate) ................................................................. Unlimited

Deductible .................................................................................................................... $200
  Effective January 1, 2011 .................................................................................. $300
  Effective January 1, 2012 .................................................................................. $400
  Effective January 1, 2013 .................................................................................. $500

When the members of a family unit have satisfied two times the individual calendar year deductible, no further deductible will be required of that family unit during that calendar year. Except that, no more than the applicable deductible amount may be satisfied by any one participant.

Eligible Expenses incurred during the last three (3) months of a calendar year that were applied to the Deductible shall also be applied to the Deductible for the next succeeding calendar year.

CO-INSURANCE

In those instances where co-insurance applies, the percentage of Covered Expenses that the Plan covers is indicated. Co-insurance means the share of the Covered Expenses which the participant must pay.
BENEFIT PERCENTAGE

Charges are paid at the benefit percentage shown:

<table>
<thead>
<tr>
<th></th>
<th>Preferred Provider</th>
<th>Non-Preferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and Board and</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td>Miscellaneous Charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery (Doctor Charges)</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td>Doctor Visits</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td>Extended Care Facility</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Doctor Visits (home and office)</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 70%</td>
</tr>
<tr>
<td>Non-Primary Care Doctor Visits (home and office)</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 70%</td>
</tr>
<tr>
<td>Urgent Center</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td>Emergency Room Charges</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 90%</td>
</tr>
<tr>
<td>X-Ray Charges</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td>Laboratory Charges</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td>Surgery Performed at:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor Office</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td>Home Health Care and Hospice Care (1)</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
</tbody>
</table>

**Prescription Drugs (2)**
- **Retail (30-Day Supply)**
  - 80% Generic ($75 Maximum Co-Pay)
  - 70% Brand Preferred ($75 Maximum Co-Pay)
  - 50% Brand Non-Preferred ($90 Maximum Co-Pay)
  - Paid At

**Prescription Drugs (Mail Order (90-Day Supply))**
- 80% Generic ($75 Maximum Co-Pay)
- 70% Brand Preferred ($75 Maximum Co-Pay)
- 50% Brand Non-Preferred ($90 Maximum Co-Pay)
  - Paid At

<table>
<thead>
<tr>
<th></th>
<th>Preferred Provider</th>
<th>Non-Preferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractor Visits</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 70%</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td>Services</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Wellness Benefits</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible, Then 70%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr. Visit Only</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid At</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td>Inpatient Doctor Visits</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td>Outpatient Doctor Visits</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 70%</td>
</tr>
<tr>
<td>Substance Abuse and Alcoholism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td>Inpatient Doctor Visits</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
<tr>
<td>Outpatient Doctor Visits</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 70%</td>
</tr>
<tr>
<td>All Other Major Medical Charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid At</td>
<td>Deductible, Then 90%</td>
<td>Deductible, Then 50%</td>
</tr>
</tbody>
</table>

**FOOTNOTES**

1. For Home Health Care, benefits will be paid for a maximum of 40 visits during a calendar year. Each four hours of service shall be considered one visit.

2. Generic substitution is automatic unless prohibited by the prescribing physician. However, if the prescribing physician does not prohibit generic substitution and the participant demands brand-name drugs be dispensed, then the participant will pay for the cost of the prescription, less the co-payment, up to the maximum allowable cost (the cost of the generic equivalent).
FULL-PAY LIMIT

After $2,000 of Covered Expenses has been paid by a Covered Person during a calendar year, or after $4,000 of Covered Expenses are paid by the family of a Covered Person during the calendar year, the plan pays 100%. Except that: charges which are subject to co-payment, and those charges which are paid at 100% without a deductible or co-payment will not apply towards reaching the $2,000 or the $4,000 and

CONTINUITY OF CARE

Services rendered by a non-preferred provider will only be considered as having been rendered by preferred providers (for benefit purposes) in the event that a preferred provider, of that specialty, did not exist in the network service area (unless the “continuity of care” or “emergency care” principles are applicable).

OUT-OF-NETWORK EXCEPTIONS

The following listing of exceptions represents services, supplies, or treatments rendered by a non-preferred provider where covered expenses shall be payable at the preferred provider level of benefits:

1. If the covered person requires emergency medical treatment and is taken to the nearest appropriate facility, the penalty will not apply. It will be considered emergency medical treatment when an accident is involved, when an illness is life threatening, or the covered person is not within a 50-mile radius of a Participating Provider when requiring medical treatment;

2. Covered services not available through any preferred provider;

3. When a covered member resides outside the service area of the Preferred Provider Organization;

4. Referral by a Network Provider to an Out-of-Network Provider.
DENTAL BENEFITS

Maximum Benefit per Calendar Year ............................................................................. $2,000
Orthodontia Maximum Benefit per Calendar Year .......................................................... $2,000
Deductible per person (Type A & B) ............................................................................... $25
Deductible per family ..................................................................................................... $50
Orthodontia Deductible per person (Type C) ................................................................. $50

TYPE “A” (PREVENTATIVE AND DIAGNOSTIC)

Benefit Percentage ........................................................................................................ 80%

1. Oral examinations, once per 6-month period.
2. Preventative treatment, consisting of:
   a) oral prophylaxis, but not more than once per 6-month period.
   b) Topical fluoride treatment available only to covered persons under 19 years of age, but in any event, not more than one treatment in a calendar year.
3. Space Maintainers for a covered person under age 19.
4. X-rays (dental X-rays, radiographs) include:
   a) Full mouth X-rays, but not more than once in any 24-month period.
   b) Supplementary bitewing X-rays, but not more than once per 6-month period with respect to a covered individual under age 25 and once a year for a covered individual age 25 or over, and
   c) Any dental X-ray required to diagnose a specific condition that needs treatment.
5. Sealants (materials, other than fluorides, painted on the grooves of the teeth in an attempt to prevent further decay). Available only to covered persons under 15 years of age.

TYPE “B” (RESTORATIVE & PROSTHONDONTICS)

Benefit Percentage ........................................................................................................ 80%

1. Extractions.
2. Restorations (includes fillings, inlays, onlays and crowns): treatment necessary to restore the structure of a tooth or teeth. If a tooth can be restored with a material such as amalgam, payment of the applicable charge for that procedure will be made toward the charge for another type of restoration selected by patient and dentist.
3. Oral Surgery: surgical procedures in and about the mouth, including extractions & implants (implantology), and excluding surgical procedures covered by your Medical Plan.
4. Endodontics (such as root canal work): procedures used for the prevention and treatment of diseases of the dental pulp.
5. Periodontics: non-surgical procedures for treatment of supporting area around the teeth and scaling of teeth.
6. Repairing or re-cementing inlays, crowns, bridgework, or dentures; or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any 36 consecutive months.
7. Injection of antibiotic drugs by the attending dentist.
8. General anesthesia when medically necessary and administered in connection with oral or dental surgery.
9. Initial installation of fixed bridgework, including inlays and crowns to form abutments (supports)
10. Initial installation of partial or full removable denture including adjustments during the six-month period after they are installed.
11. Adding teeth to an existing partial removable denture or to bridgework.
12. Installing a permanent full denture that replaces and is installed within 12 months of a temporary denture or,
13. Replacement of an existing partial or full removable denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:

   a. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed, or
   b. The existing denture or bridgework cannot be made serviceable and at least five years have elapsed prior to its replacement, or
   c. The existing denture is an immediate temporary denture which cannot be made permanent, and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

**TYPE “C” (ORTHODONTICS)**

Benefit Percentage ................................................................. 80%

Coverage is for Eligible Employees and Dependents.

1. Orthodontic diagnostic procedures (including cephalometric X-rays).
2. Surgical therapy (surgical repositioning of the jaw, facial bones, and/or teeth to correct malocclusion).
3. Appliance therapy (braces) including related oral exams, surgery and extractions.

**PRE-DETERMINATION**

Before beginning a course of treatment for which dentist’s charges are expected to be $200 or more, a description of the proposed course of treatment and charges to be made should be filed in acceptable form with Employee Plans, L.L.C. This information may be transmitted on a standard dental claim form available from the dentist or at Human Resources. Employee Plans, L.L.C. will then determine the estimated benefits payable for covered dental expenses expected to be insured, and advise the participant and the dentist before treatment begins.
VISION SCHEDULE OF BENEFITS

Maximum Payment For:

Exam (1 per 12-month period) .............................................................................................................. $65

Lenses (1 set per 12-month period) ....................................................................................................... (Per Lens)
  Single Vision .................................................................................................................................... $75
  Bifocal ............................................................................................................................................... $90
  Tri-Focal ........................................................................................................................................... $100
  Lenticular ................................................................................................................................ .......... $75

Contact Lenses – Any Type (1 set per 12-month period) ................................................................. (Per Set)
  Elective ............................................................................................................................................ $320
  Soft Lenses (Accumulative) ............................................................................................................... $320

Frames (1 set per 24-month period) ..................................................................................................... $125

Important: Either contact lenses or eyeglasses (but not both) may be obtained during a 12-month period.

EXCLUSIONS

In addition to the Exclusions listed in Section 6, the following exclusions will apply to Vision Expense Benefits:

Benefits will not be paid for:

1. Accidental bodily injury or sickness that arises out of or occurs in the course of any occupation or employment for wage or profit.

2. Services, supplies, or treatment provided by or covered by (1) the United States Government under any plan or law, or (2) any state, province, or political subdivision; and (3) any hospital or institution that does not require the individual to pay for such expenses in the absence of insurance.

3. Exams that are not performed by a doctor.

4. Supplies that are not prescribed by a doctor.

5. Charges for services or supplies that are covered under any other provision of the policy.

6. Special procedures, such as orthoptics, vision training, or subnormal-vision aids.

7. Plain or prescription sunglasses or other special-purpose vision aids.

8. Medical or surgical care of the eyes.

9. Replacement of lost or broken lenses and/or frames.

10. Duplicate glasses, lenses, or frames.

11. Services or material not listed in the Schedule of Vision Expense Benefits,

Coverage is provided for treatment of existing lenses only when required by a change in prescription and for replacement of frames only when the existing frames are not compatible with the new lenses.
SECTION 2. DEFINITIONS

This Definition Section contains information as pertains specifically to this Plan; however, the following words and phrases are not intended to imply that coverage for them is provided under the Plan.

ACCIDENT

An unforeseen or unexplained sudden injury occurring by chance involving an outside force, without intent or violation.

ACTIVE FULL-TIME

All Employees who are regularly employed by the Employer in the usual course of business and work at least thirty (30) hours per week.

ACTIVELY AT WORK

The active expenditure of time and energy by an Employee while in the Full Time Employment of the Employer, regardless of the reason for the Employee’s absence and regardless of whether the absence is related to the Employee’s health status.

ALCOHOLISM

An alcohol-induced disorder which produces a state of psychological and/or physical dependence.

AMBULATORY CARE FACILITY

A Provider with facilities and equipment for performing medical and surgical procedures to an Outpatient. The Outpatient Facility must be supervised by Physicians or a nursing staff. The facility must not be used as an office or clinic for the Physician's private practice, or provide for overnight stays.

AMENDMENT

An attached description, if any, of additional provisions to the Contract, effective only when such Amendment is signed and executed.

APPLIANCES

Those devices that are necessary for the alleviation or correction of defects of diseases including arm and leg braces; artificial arms, legs and eyes; crutches; hospital beds; pressure machines; resuscitators; traction equipment; walkers; and wheel chairs. It does not mean air conditioners; air purifiers; arch supports; articles of special clothing, bed pans, corrective shoes, dehumidifiers, dentures, elevators, eyeglasses, hearing aids, heating pads, hot water bottles, or similar devices.

BENEFIT PERCENTAGE

That portion of Eligible Expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any out-of-pocket expenses in excess of the plan year deductible which are to be paid by the Employee.
BEHAVIORAL HEALTH AND SUBSTANCE ABUSE

Mental and emotional disorders, mental and psychiatric illnesses, and other psychiatric conditions (whether organic or non-organic, whether biological, non-biological, genetic, chemical or non-chemical origin), which include, but are not limited to, psychoses, neurotic disorders, bipolar disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems and disorders, conditions and illnesses.

BENEFIT PERIOD

Refers to a calendar year. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of each calendar year;
2. The day the Maximum Lifetime Benefit applicable to the covered Person becomes payable;
3. The day the Covered Person ceases to be covered for health care benefits under the Plan.
4. The day the Plan is terminated.

BIRTHING CENTER

A facility run by at least one physician specializing in obstetrics and gynecology that is licensed as such under all applicable state and federal laws or regulations. It must accept only low-risk pregnancies, extend staff privileges to Physician practicing obstetrics and gynecology at a local Hospital, have at least two beds or rooms for labor or delivery, provide (or arrange) diagnostic x-ray and lab tests, administer local anesthesia, perform minor surgery, keep records of each patient and child, be able to arrange emergency transfers to a local Hospital, and have an ongoing quality assurance program. A Physician or certified-nurse mid-wife must be present at and right after delivery. Full-time skilled nursing services must be provided directly by a Registered Nurse (R.N.) or certified-nurse mid-wife, and trained staff must be present to handle emergencies and provide life-support services.

CALENDAR YEAR

A period of time commencing on January 1 and ending on December 31 of the same given year.

CERTIFIED NURSE-MIDWIFE

A person who is:

1. licensed as such and acting within the scope of the license; and
2. acting under proper medical direction furnished in affiliation with a Free Standing Birthing Center.

CHEMICAL ABUSE

The abuse of, dependence on or addiction to drugs or chemicals such that a pattern of behavior manifested by physical, social and emotional symptoms is intermittently or chronically present.
"COBRA"

An acronym which stands for Consolidated Omnibus Budget Reconciliation Act. It refers to Continuation of Coverage provisions which are now mandated by this Federal law.

COGNITIVE THERAPY

Treatment given to improve a Covered Person's thinking processes and intellectual capabilities.

CO-INSURANCE

The percentage in the Schedule of Benefits used to compute the amount of Covered Expenses payable by the Covered Person, when the Plan states that a percentage is payable.

COLLEGE

See definition of University.

COMPLICATIONS OF PREGNANCY

Those conditions, requiring Hospital Confinement (when pregnancy is not terminated), whose diagnoses are distinct from pregnancy but adversely affected by pregnancy, including but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion, hyperemesis gravidarum, pre-eclampsia and similar medical and surgical conditions or comparable severity, BUT SHALL NOT INCLUDE false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, gestational diabetes and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

CONTINUITY OF CARE

In an instance where care was received prior to the effective date of this plan from a provider not in the current Preferred Provider Network; and care from that provider is necessary after the effective date of this plan so as not to disrupt "continuity of care"; the benefit level will remain as "IN Network" until earlier of the date of treatment is concluded or the end of the calendar year coverage was effective.

CONTRIBUTORY COVERAGE

Group Plan benefits for which an Employee enrolls and agrees to make any required contributions toward the cost of coverage.

CONVALESCENT HOSPITAL/EXTENDED CARE FACILITY

An institution or part thereof constituted and operated pursuant to law which:

1. Provides for compensation, room and board and 24-hour skilled nursing service under the full-time supervision of a Physician or a Registered Nurse (R.N.). Full-time supervision means a Physician or Registered Nurse (R.N.) is regularly on the premises at least forty (40) hours per week;

2. Maintains a daily medical record for each patient;

3. Has a written agreement or arrangement with a Physician to provide emergency care for its patients;

4. Qualifies as an "Extended Care Facility" under the Health Insurance provided by Title XVIII of the Social Security Act;
5. For those which are not an integral part of the Hospital, has a written agreement with one or more Hospitals providing for the transfer of patients and medical information between the Hospital and Convalescent Hospital; and

6. Is licensed as such under all applicable local, state, and federal laws or regulations.

"Convalescent Hospital" includes that part or unit of a Hospital which is similarly constituted and operated to provide room and board and 24-hour nursing service for convalescent care. In no event, however, will a convalescent hospital be deemed to include an institution which is, other than incidentally, a place of rest, a place of aged, alcoholics, drug addicts, the blind or deaf, or the mentally ill or retarded; or a place for custodial care.

CO-PAYMENT CHARGE

The charge which the Covered Person is required to pay for certain Health Services provided under the Contract. The Covered Person is responsible for the payment of any Co-payment Charge directly to the provider of the Health Services at the time of service.

COSMETIC PROCEDURES

Those procedures which improve physical appearance, but which do not correct or materially improve a physiological function, and are not Medically Necessary.

COVERED PERSON

A person who has met the eligibility requirements of this Plan as an Employee or is an eligible Dependent of such Employee and whose coverage has become effective.

CUSTODIAL CARE

"Custodial Care" is care that provides a level or routine maintenance for the purpose of meeting personal needs. This is care that can be provided by a layperson who does not have professional qualifications, skills, or training. Custodial Care includes, but is not limited to, help in walking and getting into or out of bed; help in bathing, dressing, and eating; help in other functions of daily living of similar nature; administration of or help in using or applying medications, creams and ointments; routine administration of medical gasses after regimen of therapy has been set up; routine care of a patient, including functions such as changes of dressings, diapers and protective sheets and period turning and position in bed; routine care and maintenance in connection with casts, braces and other similar devices, or other equipment and supplies used in treatment of a patient, such as colostomy and ileostomy bags and indwelling catheters; routine tracheostomy care; general supervision of exercise programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services.

DEDUCTIBLE

A specified dollar amount of Eligible Expenses not payable under the Plan which must be incurred during a Benefit Period before any other Eligible Expenses incurred during the Benefit Period can be considered for payment according to the applicable Benefit Percentage.

DEPENDENT

Dependent is any one of the following persons:

1. A covered Employee's Spouse and children from birth to the limiting age of twenty-six (26) years. Coverage will end on the Dependent's 26th birthday. However, a Dependent child will continue to be covered after age 26 provided the child is a full-time student at an accredited school, college, or university and under the limiting age of 27.
The term "Spouse" shall mean the legally recognized marital partner of a covered Employee between a man and a woman, regardless of whether a state recognizes same-sex marriages. The Plan Administrator may require documentation proving a marital relationship.

The term "children" shall include natural children, stepchildren, adopted children or children placed in the covered Employee's home in anticipation of adoption.

The term “children” shall also include a child for whom the Employee has been granted legal guardianship and who lives in the Employee's household.

As required by the Federal Omnibus Budget Reconciliation Act of 1993, any child of a Plan Participant who is an alternate recipient under a qualified medical child support order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan.

2. A covered Dependent child who is unmarried and incapable of self-sustaining employment by reason of mental retardation or physical handicap, primarily dependent upon the covered Employee for support and maintenance. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both husband and wife are Employees, their children will be covered as Dependents of the husband or wife, but not of both.

DENTAL SERVICES

Procedures involving the teeth, gums or supporting structures.

DENTIST

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

DISABILITY/PERIOD OF DISABILITY

In the case of a Covered Person, any period of Illness or Injury, or multiple illnesses or injuries arising from the same cause, including any and all complications therefrom, which are not separated by a complete recovery (as certified by the attending Physician) and return to active full-time employment; or in the case of a Dependent, return to the resumption of the normal activities of a person of the same age and sex in good health.
DRUG ADDICTION

A substance-induced disorder which produces a state of psychological and/or physical dependence.

DRUG ADDICTION/ALCOHOLISM TREATMENT FACILITY

1. A public or private facility providing services especially for the detoxification or rehabilitation of drug addicts or alcoholics for those services; or
2. A comprehensive health service organization, community mental health center or other mental health clinic or day care center which furnished mental health services with the approval of the appropriate governmental authority, any public or private facility or portion thereof providing services especially for the rehabilitation of drug addicts or alcoholics and which is licensed for those purposes, which is licensed as such under all applicable local, state and federal laws or regulations.

DURABLE MEDICAL EQUIPMENT

Medical equipment which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of a Sickness or Injury, and is appropriate for use in the home.

EMERGENCY CARE

Care for a serious medical condition resulting from injury or illness which arises suddenly and requires immediate care and treatment.

EMPLOYEE

A person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

EMPLOYER means East Allen County Schools.

EXPERIMENTAL AND INVESTIGATIONAL TREATMENTS, PROCEDURES, DRUGS AND DEVICES

The term “Experimental” when used in reference to a drug, device, treatment and/or a procedure (other than covered Off-Label Drug Use) means a drug, device, treatment and/or a procedure that satisfies one (1) or more of the following:

1. a drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and which has not been so approved for marketing at the time the drug or device is furnished; or
2. a drug, device, treatment or procedure which Reliable Evidence shows is the subject of an on-going Phase I, II or III clinical trial or is under study to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
3. a drug, device, treatment or procedure for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, it toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis; or
4. the treatment or procedure is less effective than conventional treatment methods; or
5. a review of the number of patients who have received this treatment indicates that the patients who have received the treatment or procedure, received it during Phase I, II or III of the clinical trial of the development of the treatment or procedure; or

6. the procedure or treatment is currently undergoing review by the Institutional Review Board (or similar body) for the treating health care facility; or

7. the language appearing in the consent form or in the treating Hospital's protocol for treatment indicates that the Hospital or the Physician regards the treatment or procedures as experimental; or

8. a drug or device that is used in a manner or as a treatment for which it was not approved by the Food and Drug Administration; or

9. any drug, device, treatment or procedure that is considered experimental or investigational under the Medicare Coverage Issues Manual.

“Reliable Evidence” means 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, treatment or procedure; or the written informed consent form used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedures with respect to the condition of the Covered Person in question.

EXTENDED CARE FACILITY

A Provider whose main purpose is to provide skilled nursing services to Inpatients. The Inpatients must require convalescent and rehabilitative care by or under the supervision of Physician. Eligibility for payment is based on care that complies with Medicare-established guidelines. It is not a place that primarily provides Custodial Care, part-time care, ambulatory care, or care or treatment for Mental and Nervous Disorders, alcoholism, drug abuse, or pulmonary tuberculosis.

FAMILY COVERAGE

Coverage for the Participant and his or her Dependents under the Plan.

GENERIC NAMES

Drugs not labeled by brand names (the manufacturers’ trade name). The chemical composition is the same for generic drugs as it is for brand name drugs.

HIPAA

The Health Insurance Portability and Accountability Act of 1996.

HOME HEALTH CARE AGENCY

A service or agency providing home health care and possessing a valid certificate of approval issued in accordance with Title XVIII of the Social Security Act, that is licensed as such under all applicable local, state and federal laws or regulations.

HOME HEALTH CARE PLAN

A program for care and treatment of a Covered Person that has been established and approved in writing by the Covered Person's attending Physician which states that the proper treatment of the Injury or Illness requires confinement as a resident inpatient in a Hospital or an Extended Care Facility as defined in the Title XVIII of the Social Security Act.
HOSPICE

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

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

HOSPICE BENEFIT PERIOD

A specified amount of time during which the Covered Person undergoes treatment by a Hospice. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminal illness or Injury, and the Covered Person is approved for a Hospice program by the Employer. The period shall end the earliest of six (6) months from such date or at the death of the Covered Person. A new benefit period may begin if the attending Physician certifies that the patient is still terminally ill; however, additional proof may be required by the Employer before such a new benefit period can begin.

HOSPITAL

An institution which meets all of the following requirements:

1. Is primarily engaged in providing, by or under the continuous supervision of Physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured sick persons;
2. Has organized departments of medicine and surgery;
3. Has a requirement that every patient must be under the care of a Physician or Dentist;
4. Provides 24-hour nursing service by or under the supervision of a Registered Nurse (R.N.);
5. Is licensed as such under all applicable local, state and federal laws or regulations.
6. Is not, other than incidentally, a place of rest; a place primarily for the treatment of tuberculosis, mental or emotional disorders; a place for the aged, drug addicts or alcoholics; or a place for custodial care;
7. Is accredited by the Joint Commission Accreditation of Hospital Organizations (J.C.A.H.O.).
Services rendered in the infirmary or clinic of a college, university or private board school shall be Eligible Expenses. In such instances, if a Covered Person is confined in a school facility that does not meet the definition of a Hospital because it has no operating room, benefits may be paid, provided the charges for such confinement do not exceed the Usual, Reasonable and Customary Charges.

**HOSPITAL CONFINEMENT OR CONFINED IN A HOSPITAL**

An individual will be considered confined in a Hospital if he is a registered bed patient in a Hospital upon the recommendation of a Physician, is a patient in a Hospital because of surgical operation, or is a patient receiving emergency care in a Hospital for an Injury within 48 hours after the Injury is received, or is an outpatient in a Hospital because tests were ordered by a Physician within four (4) days prior to an admission on an Inpatient Basis to the same hospital.

For the purpose of determining the benefits payable, two (2) partial Days of Confinement in a Hospital will be considered one Day of Confinement. Partial confinement means continuous treatment for at least three (3) hours but not more than twelve (12) hours in any 24-hour period.

**HOSPITAL EMERGENCY ROOM VISIT**

The Hospital's total, eligible charge for the emergency room treatment.

**HOSPITAL MISCELLANEOUS EXPENSE**

The actual charges made by a Hospital on its own behalf for services and supplies rendered to the Participant. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

**ILLNESS/SICKNESS**

A disorder of the body or mind, a disease, or pregnancy. All illnesses which are due to the same cause or to a related cause or causes will be deemed to be one illness.

**INCURRED EXPENSE**

The charge for a medical treatment, service or supply rendered to a Participant. Such charge shall be considered to have been incurred on the date the treatment or service was provided or the supply purchased.

**IN-NETWORK SERVICES**

Services provided by a Network Provider.

**INJURY**

Accidental bodily Injury caused by unexpected external means which does not arise out of or in the course of employment and which results in a loss covered by the Plan. This definition does not include any intentionally self-inflicted Injury; whether sane or insane.

**INTENSIVE/CORONARY/ACUTE CARE CHARGE**

A service which is normally reserved for critically and seriously ill patients requiring constant audio-visual surveillance; provides room and board; provides care by Registered Nurse (R.N.) or other highly trained hospital personnel; has special equipment and supplies immediately available on a standby basis; and is provided at a location segregated from the rest of the Hospital's facilities. This term does not include care in a surgical recovery or postoperative room.
LARGE CLAIM MANAGEMENT SERVICES

A program designed specifically to identify catastrophic or potentially catastrophic claims while they are still being incurred and to investigate alternate treatment programs which offer both quality care and cost savings.

LATE ENROLLEE

Any individual who does not enroll in this Plan when first eligible, but shall not include any individual who enrolls within thirty (30) days after; (i) the date the Employee acquires a new Dependent; (ii) the date the Employee loses coverage under the Employee's spouse's group health plans because of the spouse's ineligibility; (iii) the date Covered Person's COBRA coverage under another group plan is exhausted; or (iv) the date the Employee's spouse terminates health plan coverage because the spouse's employer completely discontinued to subsidize the group health plan.

LEGEND DRUGS

Drugs or medications which require a Federal warning stating, "Caution: Federal Law prohibits dispensing without a prescription."

LICENSED PRACTICAL NURSE

An individual who has received specialized nursing training and practical nursing experience, and is duly licensed under all applicable local state and federal laws or regulations to perform nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

LONG-TERM REHABILITATION SERVICES

Long-Term Rehabilitation Services are services for a condition where the condition is not expected to improve significantly within ninety (90) consecutive calendar days of the onset of the therapy and include, but are not limited to, long-term speech, physical, respiratory, occupational, vestibular and cardiac rehabilitation.

LIFE EVENT

Marriage, divorce, death of spouse, or child, birth, adoption, change of spouse's employment status and significant change in alternate coverage under another group plan.

LIFETIME

Is a word that appears in this Plan in reference to 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.

MEDICAL EMERGENCY

The sudden onset of severe medical symptoms that:

1. could not have been reasonably anticipated; and
2. require immediate medical treatment.
MEDICALLY NECESSARY

A service, drug, or supply if necessary and appropriate for the diagnosis or treatment of a Sickness or Injury in accordance with generally accepted standards of medical practice in the U.S. at the time the service, drug or supply is provided. When specifically applied to a confinement it further means that the diagnosis or treatment of the person's symptoms or condition cannot be safely provided to that person on an outpatient basis.

A service, drug, or supply shall not be considered as Medically Necessary if it:

1. Is investigational, experimental, or for research purposes; or
2. Is provided solely for the convenience of the patient, the patient's family, physician, hospital or any other provider; or
3. Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; or
4. Could have been omitted without adversely affecting the person's condition or the quality of medical care; or
5. Involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration; or
6. Involves a service, supply or drug not approved for reimbursement by the Health Care Financing Administration.

Benefits payment is subject to the determination of the Plan Administrator that the service, drug or supply is Medically Necessary.

MEDICARE

The Part A and Part B plans described in Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HOSPITAL

An institution, other than a Hospital, which specializes in the diagnosis and treatment of Mental Illness or functional nervous disorder which is operated pursuant to law and meets all of the following requirements:

1. Is licensed to give medical treatment;
2. Is operated under the supervision of a Physician;
3. Offers nursing services by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);
4. Provides, on the premises, all the necessary facilities for medical treatment;
5. Is not, other than incidentally, a place of rest; a place for the aged, drug addicts or alcoholics; or a place for convalescent, custodial or educational care; and
6. Is licensed as such under all applicable local, state and federal laws or regulations.

NETWORK PHYSICIAN

A Physician who, at the time of providing or authorizing services to the Member, has entered into a contract (or on whose behalf a contract has been entered into) with the Plan to accept Plan negotiated reimbursement for professional services provided to Members.

NONCONTRIBUTORY COVERAGE

Group Plan benefits for which the Employee enrolls and for which he is not required to make contributions toward the cost of coverage.
OCCUPATIONAL THERAPY
Treatment which primarily consists of instructing a covered person on performing normal activities of daily living.

OFF-LABEL DRUG USE
The use of a drug for purpose other than that for which it was approved by the FDA.

ORTHOTIC APPLIANCE
An external device designed specifically for the Covered Person and intended to correct a defect from or function of the human body.

OTHER HOSPITAL CHARGES
Includes any charges, other than charges for room and board, made by a Hospital on its own behalf for necessary medical services and supplies actually administered during Hospital Confinement. Necessary services and supplies will also include any charges, by whomever made, for professional ambulance service to or from the nearest Hospital where the medical care and treatment necessary for the individual can be provided, and any charges for the administration of anesthetics during Hospital confinement, but will not include any charges for the special nursing fees, dental fees or medical fees.

OUTPATIENT
The classification of a Covered Person when that Covered Person received medical care, treatment, services or supplies at home, a minor emergency medical clinic, and Ambulatory Surgical Center, a Physician's office, a Hospital, an Outpatient Psychiatric Facility or an Outpatient Alcoholism Treatment Facility, if not a registered bed patient.

OUTPATIENT ALCOHOLISM TREATMENT FACILITY
An institution which provides a program for: diagnosis, evaluation, and effective treatment of alcoholism; detoxification services needed with such treatment program; infirmary-level medical services or arranges for a Hospital in the area for any other medical services that may be required; supervision at all times by staff of Physician; skilled nursing care at all times by Licensed Practical Nurses (L.P.N.) or Registered Nurses (R.N.) who are directed by a full-time Registered Nurse (R.N.); preparing and maintaining a written plan of treatment for each patient based on medical, psychological and social needs; and when meeting all applicable local, state and federal laws and regulations.

OUTPATIENT PSYCHIATRIC FACILITY
An administratively distinct governmental, public, private or independent unit or part of such unit that provides Outpatient mental health services and a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

OUT-OF-NETWORK SERVICES
Services not provided by a Network Provider.

PARTICIPANT
An Employee or Dependent who is eligible to participate in this Plan and who satisfactorily completes all enrollment procedures.
PHARMACY

A licensed establishment where prescription drugs are dispensed by a pharmacist.

PHYSICAL THERAPY

Treatment given to improve the physical capabilities of a covered individual in an attempt to restore such individual to a previous level of good health.

PHYSICIAN

A qualified, licensed doctor of medicine or osteopathy, and any other licensed health care provider that state law requires to be recognized as a Physician, and practicing within the scope of his license. This does not include the Participant, or his or her spouse, parent, son, daughter, brother or sister.

PLAN

The terms and conditions of the benefit plan described herein.

PLAN YEAR

The 12 month period commencing September 1 and ending August 31.

PRE-EXISTING CONDITION

Any illness or injury (except pregnancy) for which medical care, diagnosis or treatment was received or recommended within six (6) months prior to the date the Employee enrolls in this Plan (the first day of the enrollment waiting period, if earlier). Any further treatment for such illness or injury shall be excluded under this Plan until the earlier of: the date ending 90 consecutive days during which no confinement has existed or no treatment or service has been received for the Pre-Existing conditions; or for twelve (12) months (eighteen (18) months for LATE ENROLLEES) after the date of enrollment. This exclusion period will be reduced by the amount of time the covered person was continuously covered by another group health plan, individual insurance policy, or governmental health program provided that the Covered Person provided a certificate evidencing such coverage and provided further that the Covered Person does not experience a gap in coverage over sixty-two (62) days.

PREFERRED PROVIDER ORGANIZATION (PPO)

The network with which the Plan Administrator has designated to provide quality Medical Care and services. The PPO network will deliver medical services at contracted fees for the Covered Person.

PRIVATE DUTY NURSING SERVICES

Skilled services which are furnished by or under the direct supervision of skilled personnel to assure the safety of the patient and achieve the medically desired result, and for which the planning and management of a treatment plan requires the continuing involvement of a licensed nurse.

PSYCHIATRIC SERVICES/TREATMENT

Treatment of Mental Illness including services provided by a Physician, and services provided by a Psychologist, certified drug or alcohol counselors, or clinical social worker who is licensed as such under all applicable local, state and federal laws or regulations, which services and treatment care related to alcoholism, chemical addiction or abuse, and drug addiction or abuse.
PSYCHOLOGIST

An individual who is duly licensed or certified as a psychologist under all applicable local, state and federal laws and regulations.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

An order issued by a court that creates or recognizes the right of a Plan Participant's child (alternate recipient) to receive benefits under the same Plan providing coverage to the Plan Participant. To be a "qualified" order, the following information must be included:

1. the name and last known address of the Plan participant and each alternate recipient;
2. a "reasonable" description of the type of coverage to be provided by the Plan to each alternative recipient; or the manner in which type of coverage is to be determined;
3. the period to which the order applies; and
4. each Plan to which the order applies.

REGISTERED NURSE

An individual who has received specialized nursing training, is authorized to use the designation "R.N.", and who is duly licensed under all applicable local, state and federal laws and regulations.

REHABILITATIVE CARE

Necessary inpatient medical care which is prescribed by a Physician, rendered in a Rehabilitation Hospital, excluding custodial care or occupational training.

REHABILITATION HOSPITAL

A facility which meets all the requirements of a Hospital, except that a surgery department is not required. In addition, it must meet the following criteria:

1. It must be accredited by the Joint Commission Accreditation of Hospitals (J.C.A.H.O.) and be approved for federal Medicare benefits as a qualified Hospital;
2. It must maintain transfer agreements with Hospitals to handle surgical and/or medical emergencies;
3. It must maintain a utilization review committee;
4. Is licensed as such under all applicable local, state and federal laws and regulations.

REVIEW AGENT

The company appointed by the Plan Administrator to evaluate medical information against professionally endorsed standards of medical care.
ROOM AND BOARD

Refers to the expenses incurred by an Inpatient which are made by Hospital as a condition of occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care by whatever name called.

ROUTINE NURSERY CHARGES

Hospital charges for nursery room and board, the initial pediatric examination made by a Physician, charges by a pediatrician for attendance at a cesarean section and circumcision performed while the newborn Child is in the Hospital or Birthing Center at the time of birth, or for care other than treatment due to sickness or injury.

SECOND SURGICAL OPINION

When surgery is prescribed, a Second Surgical Opinion is recommended. This Second Surgical Opinion is to determine the necessity of the proposed surgery and must be provided by a Board Certified Physician who is qualified to render such a service and who is not affiliated in any way with the Physician who will be performing the surgery.

SEMI-PRIVATE ACCOMMODATIONS

A room with two or more beds in a Hospital or Skilled Nursing Facility approved by PLAN. The difference in cost between Semi-private Accommodations and private accommodations is Covered only when private accommodations are Medically Necessary.

SKILLED NURSING FACILITY

A lawfully operated institution, or its distinct part which:

1. Has the primary purpose of providing day and night lodging and skilled nursing care for persons recovering from an Injury or Illness;
2. Is supervised on a full-time basis by a Physician or Registered Nurse (R.N.);
3. Admits patients only upon the advise of a Physician, keeps clinical records on all patients and has the services of a Physician available;
4. Has established methods and procedures to dispense and administer drugs and biologicals;
5. Has a written agreement with one or more Hospitals;
6. Is not, except incidentally, a place for rest, for the aged, for drug addicts, for alcoholics, or for the mentally ill; and
7. Is licensed as such under all applicable local, state and federal laws and regulations.

SOCIAL WORKER

An individual who is duly licensed and holds a master's degree in social work from a university approved by the National Association of Social Workers (NASW) and who is practicing under the supervision of a Psychiatrist or Psychologist.
SPECIAL ENROLLMENT

Any individual who enrolls within thirty (30) days after: (i) the date an Employee acquires a new Dependent; (ii) the date an Employee loses coverage under the Employee’s spouse’s group health plan because of the spouse’s ineligibility; (iii) the date a Covered Person’s COBRA coverage under another group plan is exhausted; or (iv) the date the Employee’s spouse terminates health plan coverage because the spouse’s employer completely eliminates any employer subsidy for the group health plan. Additionally, any individual who enrolls within sixty (60) days after the individual (Employee or Dependent) (i) is covered under a Medicaid or a state’s Children’s Health Insurance Program ("CHIP") and the CHIP coverage of the Employee or Dependent under the Medicaid or CHIP plan is terminated as a result of loss of eligibility for such coverage or (ii) becomes eligible for a premium assistance subsidy with respect to coverage under this Plan, and the Employee requests coverage under the Plan within sixty (60) days after the date the Employee or Dependent is determined to be eligible for the premium assistance subsidy. The preceding sentence shall be effective April 1, 2009.

SPEECH THERAPY

Treatment administered to improve a participant's speech capabilities after a decrease in those capabilities following an illness.

SUBSTANCE ABUSE

The condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results 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.

TERMINAL ILLNESS

An illness where the medical prognosis is of a life expectancy of six (6) months or less if the illness runs its normal course.

THIRD PARTY ADMINISTRATOR

The entity designated by the Employer to process claims under this Plan.

TOTAL DISABILITY

An Employee who is prevented, because of an Injury or Illness, from engaging in his regular or customary occupation and who is performing no work of any kind for compensation or profit or a Dependent of a Covered Person who is prevented, solely because of an Injury or Illness, from engaging in all of the normal activities of a person of like age and sex in good health.

UNIVERSITY

An institution of higher learning providing facilities for teaching and research and authorized to grant academic degrees.

URGENT CARE

Care for a medical condition resulting from injury or illness which is less severe than emergency care but requires care within a reasonably short time.

USUAL, CUSTOMARY AND REASONABLE (UCR)

Charges made for medical services or supplies essential to the care of the individual if they are in accordance with:
1. the "usual" fee which is the fee an individual Physician most frequently charges the majority of his patients for the procedure performed; and

2. the "customary" fee which is the fee established by the Plan based on charges made by most Physicians of the same specialty in comparable geographical economic areas for the procedure performed; or

3. the "reasonable" fee which is the fee charged for unusual circumstances involving medical complications, requiring additional time, skill and experience.

**VOCATIONAL REHABILITATION**

Teaching and training which allows a Covered Person to resume his or her previous job or to train for a new job.

**WAITING PERIOD**

The number of days stated on the Schedule of Benefits during which time a Participant must be a continuous, active, full-time, permanent employee of the Plan Sponsor prior to becoming eligible for coverage under this Plan.

**WELL-BABY CARE**

Medical treatment, services or supplies rendered to an infant solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.
SECTION 3. ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY OF COVERAGE

Coverage provided under the Plan for Employees and their Dependents shall be in accordance with the Eligibility, Effective Date, and Termination provisions stated in the Plan Document, including any Coverage Classification described on the Schedule of Benefits page.

If benefits differ by Coverage Classifications (if any) shown on the Schedule of Benefits, any change in the amount of coverage available to a Covered Person occasioned by a change in the Employee's classification shall become effective automatically on the classification change date.

If an Employee's coverage is continued during disability, approved leave of absence or temporary lay-off or as approved under the Family Medical Leave Act, the amount of coverage shall be the amount as it was on the last day of active work; in no event shall this coverage be continued for longer than 90 days or until the end of the month in which their benefit days are exhausted.

When an employee is granted a leave of absence, other than FMLA, by the Board, they may continue the group insurance program during the leave period by paying the full premium.

Those employees leaving the employment of the Board because of retirement may remain a part of the group plan by paying the full premium. When eligible for Medicare Part B, the retiree and dependents must enroll in Medicare and EACS’ health plan will be supplementary to Medicare.

An employee may become eligible for normal (unreduced) retirement:

1. At age 65 with at least 10 years of creditable service.
2. At age 60 with at least 15 years of creditable service, or
3. At age 55 if age and creditable service total at least 85 (this is called the “Rule of 85”).

Employees and Dependents who are Late Enrollees cannot be enrolled in this Plan unless they experience a Special Enrollment Event as defined herein.

EMPLOYEE ELIGIBILITY

An Employee eligible for coverage under the Plan shall include only Employees who meet all of the following conditions:

1. Is within a Coverage Classification;
2. Is actively at work.

With respect to an eligible Employee employed by the Employer on the Effective Date of the Plan, the date of his eligibility shall be the Effective Date of the Plan.

With respect to an eligible Employee who becomes employed by the Employer after the Effective Date of the Plan, the date of his eligibility shall be the day he first comes within a Coverage Classification (if any) shown on the Schedule of Benefits.

If an employee is laid off while in their 90 day waiting period, once called back to work, within their call rights, the work days already accrued will be credited towards their total 90 day waiting period. In other words, they will not have to start the waiting period all over again.
SPOUSAL CARVE-OUT – applicable to all employees hired after August 1, 2010

If an employee has a spouse working elsewhere who is eligible for group health benefits at their place of employment, he/she must take the group health insurance at their place of employment, unless their cost for the single plan is greater than two (2) times the employees' cost for the single plan at East Allen County Schools. If the spouse takes their employer’s group health insurance, the spouse may enroll in East Allen County School’s Group Health Insurance Plan, but the plan will pay only on a secondary basis.

DEPENDENT ELIGIBILITY

An Employee may enroll a Dependent, provided the Dependent satisfies the definition of a Dependent. An Employee will become eligible for Dependent coverage on the latest of the following:

1. The date the Employee becomes eligible for coverage;
2. The date on which the Employee first acquires a Dependent if the Employee is covered on that date;
3. The date he or she first comes within a Coverage Classification (if any) eligible for Dependent coverage as shown on the Schedule of Benefits.

If both the Employee and spouse are employed by the Employer, and both are eligible for Dependent coverage, either (but not both) are eligible for Dependent coverage, and either (but not both) may elect Dependent coverage for their eligible Dependents.

A Dependent shall be considered eligible for coverage on the date the Employee becomes eligible for Dependent coverage, subject to all limitations and requirements of the Plan, and subject to the following rules and limitations:

1. A newborn Child of a covered Employee will be covered from the moment of birth for Injury or Illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled as a Dependent of the Employee within thirty (30) days of the child's date of birth. However, a newborn child will be automatically covered if the employee is already enrolled for dependents' coverage. This provision shall not apply, nor in any way affect the normal maternity provisions applicable to the mother;
2. A spouse of a covered Employee will be considered a Dependent from the date of marriage, provided the spouse is properly enrolled as a Dependent of the Employee within thirty (30) days of the date of marriage;
3. If a Dependent is acquired, other than at the time of his birth, due to a court order, decree, or marriage, that Dependent will be considered a Dependent from the date of such court order, decree, or marriage, provided that this new Dependent is properly enrolled as a Dependent of the Employee within thirty (30) days of the court order, decree of marriage.
4. A Dependent shall also include a child who is placed for adoption with the Plan Participant and is to be considered having the same status and rights under the Plan as a natural child of a Covered Employee, even if the adoption has not become final according to the court having jurisdiction over such adoption. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of the child. Coverage for such a child will not be restricted by invoking any preexisting condition provision of the Plan.
5. A Dependent shall also include a child under a Qualified Medical Child Support Order (QMCSOs). In accordance with the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), the Plan Administrator must recognize QMCSOs. A QMCSO is defined as a medical support order which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Participant or beneficiary is eligible under the Group Plan. A child who is identified in such an order is designated an "alternate recipient" and has the same status and rights as any other child covered under the Plan. Alternate recipient is defined as any child of a Covered Employee who is recognized under a medical child support order as having a right to be enrolled under the Plan. The Plan Administrator must perform the following duties in conjunction with the QMCSO:

a. notify the Covered Employee and alternate recipient(s) that an order has been received;
b. inform the Covered Employee and alternate recipient(s) of the Plan's procedures used in determining if the order is qualified as a QMCSO. Such procedures must be in writing and provide for prompt notification of all interested parties, including the Claims Administrator; and
c. determine, within a reasonable amount of time, if the order is a qualified QMCSO and notify all interested parties, including the Claims Administrator.

EMPLOYEE EFFECTIVE DATE

Employee coverage under the Plan shall become effective with respect to an eligible person on the date of his eligibility, provided written application for such coverage and any contribution required from such person is made on or before such date. If application is made within thirty (30) days after the date of eligibility, the Employee coverage for the eligible person shall become effective on the original eligibility date.

An Employee's coverage under the Plan shall commence at 12:01 A.M. Standard Time, on the date such coverage is effective.

DEPENDENT EFFECTIVE DATE

Each Employee who makes written request for Dependent coverage under the Plan, on a form approved by the Plan Administrator, will become covered for Dependent coverage as follows:

1. if the Employee makes such written request within thirty (30) days of the date the Dependent is first eligible to enroll, then Dependent coverage will be effective on the date the Dependent becomes eligible for Dependent coverage;

SPECIAL ENROLLMENT

The Health Insurance Portability and Accountability Act of 1996 requires that group health programs allow certain individuals to be covered by the Plan as Special Enrollees as follows:

1. If an otherwise eligible Employee or Dependent declined coverage under the Plan at the time of initial eligibility, and stated in writing at that time that coverage was declined because of other health coverage and that other health coverage is subsequently lost, and that person makes application for coverage hereunder within 30 days of the loss of the other health coverage, such individual shall be a Special Enrollee provided such person: (a) lost the alternative health coverage 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, but not including an increase in cost of the coverage or reduction in benefits of the other coverage); or (b) employer contributions toward such other coverage were terminated; or (c) if the eligible Employee or Dependent was covered
under a COBRA continuation provision and the COBRA continuation period has been exhausted. Individuals who lose other health coverage due to nonpayment of premium or for cause (e.g., filing fraudulent claims) shall not be a Special Enrollee hereunder.

2. An otherwise eligible Employee who is not covered by the Plan, an otherwise eligible Employee and Dependent who are not covered by the Plan, or a Participant's Dependent who is not otherwise covered by the Plan may apply for coverage under the Plan as a result of the acquisition of a new Dependent by the Participant through marriage, birth, adoption or placement for adoption and shall be a Special Enrollee provided such person is properly enrolled as a participant or Dependent of the Participant within thirty (30) days of the acquisition of the new Dependent.

3. A newborn child, a child placed for adoption, or a newly adopted child of a covered Participant will be covered from the moment of birth, placement for adoption, or adoption, including coverage for the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled as a Dependent of the Participant within thirty (30) days of the child’s date of birth, adoption, or placement for adoption.

4. Coverage for a Special Enrollee who is a newborn child, a child placed for adoption, or an adopted child shall begin as of the date of birth, placement for adoption, or adoption.

5. Coverage for a Special Enrollee, other than a newborn, a child placed for adoption, or a newly adopted child, shall begin following termination of the other coverage and within thirty (30) days of the Special Enrollment event.

TERMINATION OF COVERAGE

Employee and Dependent coverage for a particular benefit shall terminate immediately on the earliest of the following dates:

1. The last day of the employee’s employment, not extended by unused vacation; provided that coverage may be extended during leave of absence that qualifies as leave under the provision of the Family Medical Leave Act of 1993;

2. Date the Employee ceases to be in a class eligible for coverage;

3. Date the Employee fails to make any required contribution for coverage;

4. Date the Plan or a particular benefit is terminated;

5. Date the Employee dies;

6. Date the Employee becomes a full-time member of the armed forces of any country.

7. Date the Dependent fails to qualify as an eligible Dependent.

8. If an employee leaves the employ of the Board after the end of the school year, full insurance coverage shall continue until the first contract day of the following school year. If an employee leaves the employ of the Board on or to the last contract day of the school year, they may continue the prior plan an additional ninety (90) calendar days, or longer, if mandated by law, from the last day of the month their employment ends, by paying the full premium.
REINSTATEMENT AFTER TERMINATION OF COVERAGE

If coverage ends during a lay-off or approved leave of absence, and the Employee returns to work within 12 months of the lay-off or leave of absence, the Employee will be eligible for coverage immediately upon return to work, providing request to re-enroll is made within 30 days of return to work.

If coverage was not continued during this period under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), then the pre-existing condition clause will apply to the employee and his eligible dependents.

ADOPTED CHILDREN COVERAGE

A Child placed with an Employee for adoption will be an Eligible Dependent. Coverage for that Child will begin on the later of:

1. the date coverage for the Employee's other Eligible Dependents begins;
2. the date the Child is placed with the Employee for adoption.

Coverage for the Child will end on the date the Child is no longer in the Employee's custody for adoption.

STATEMENT OF HIPAA PORTABILITY RIGHTS

PRE-EXISTING CONDITION EXCLUSIONS

Some group health plans restrict coverage for medical conditions present before an individual’s enrollment. These restrictions are known as “pre-existing condition exclusions.” A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your “enrollment date.” Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption nor shall it apply to a participant under the age of nineteen (19).

If a plan imposes a pre-existing condition exclusion the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children’s Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to void a 63-day break.

RIGHT TO GET SPECIAL ENROLLMENT IN ANOTHER PLAN

Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request another enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.) Therefore, once your coverage in a group health plan ends, if you are eligible for coverage in another plan (such as a spouse’s plan), you should request special enrollment as soon as possible.
PROHIBITION AGAINST DISCRIMINATION BASED ON A HEALTH FACTOR

Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

RIGHT TO INDIVIDUAL HEALTH COVERAGE

Under HIPAA, if you are in an “eligible individual,” you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

1. You have had coverage for at least 18 months without a break in coverage of 63 days or more;
2. Your most recent coverage was under a group health plan;
3. Your group coverage was not terminated because of fraud or nonpayment of premiums;
4. You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
5. You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing our eligible individual status due to a 63-day break.

STATE FLEXIBILITY

This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

FOR MORE INFORMATION

If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for “Protecting Your Health Insurance Coverage”). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa or http://www.cms.hhs.gov/hipaa1.

CREDITABLE COVERAGE

Creditable coverage is coverage under any kind of health benefit policy or program, including a group health plan, individual health insurance coverage, Medicare or Medicaid.

CERTIFICATES OF CREDITABLE COVERAGE

In general, certificates of creditable coverage must be in writing and must state: the date of issue, the plan name; the names of the participants or covered dependents; the name, address and telephone number of the party providing the certification; either a statement that the individual has at least eighteen (18) months of creditable coverage or the date any waiting period and period of creditable coverage began; and the date coverage ended.

The Plan Administrator shall send Certificates of Group Health Plan Coverage according to the “Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), under the following conditions when notified by Employer:

1. For loss of coverage on or after 6/1/97.
2. When COBRA expires or is terminated by the COBRA continuee.
3. Upon written demand from insured, if loss of coverage occurred within twenty-four (24) months of the date of the request.
DETERMINING CREDITABLE COVERAGE

No Pre-Existing Condition exclusion will be imposed on any covered individual unless it discloses its determination that a pre-existing exclusion period applies and the basis for its determination. This determination will be made within a reasonable time of the Plan’s receipt of a Certificate of Coverage or other demonstration.

IF A CERTIFICATE OF COVERAGE IS NOT AVAILABLE

A Participant may demonstrate creditable coverage if a certificate of coverage is unavailable or insufficient for some reason. An individual will be treated as having furnished a certificate if the individual attests to the period of coverage, provides relevant evidence (such as explanation of benefit forms, health insurance identification cards, or pay stubs), and cooperates with the plan’s effort to verify coverage. This may be verified with a telephone call.

REDUCTION OF PRE-EXISTING CONDITION EXCLUSION PERIOD BY PRIOR CREDITABLE COVERAGE

The Pre-Existing Condition exclusion period described above shall be reduced by the individual’s days of Creditable Coverage as of the day such individual becomes eligible, or, if the individual’s coverage under the Plan is delayed for a specified waiting period, as of the first day of such individual’s waiting period (typically the individual’s first day of employment). Notwithstanding the preceding sentence, days of Creditable Coverage that occur before a “significant break in coverage” shall not be counted in reducing a Pre-Existing Condition exclusion. A “significant break in coverage” as defined in the regulations under HIPAA, generally means a period of sixty-three (63) consecutive days during all of which the policy nor an affiliation period is taken into account in determining a significant break in coverage.

PROCEDURES FOR REQUESTING CERTIFICATE OF CREDITABLE COVERAGE

The Plan will provide an individual who loses coverage under the Plan or terminates coverage under COBRA, a certificate of creditable coverage documenting an individual’s length of coverage under the Plan. A certificate will also be provided to individuals who take leave under The Family and Medical Leave Act if they do not continue coverage under this Plan. Covered Person may also request a certificate up to 24 months after coverage ceases, pursuant to the following procedures:

1. The individual must request a certificate in writing either via U.S. Mail or facsimile to the Plan Administrator at the address and phone number listed in Section 16.06.
2. The individual must provide the specific address where the certificate shall be sent.
3. All certificates shall be mailed via first class U.S. Mail postage prepaid.
SECTION 4. MAJOR MEDICAL EXPENSE BENEFITS

BENEFIT PERCENTAGE AND DEDUCTIBLE

The Plan will pay the Benefit Percentage shown on the Schedule of Benefits for Eligible Expenses incurred in each Benefit Period, unless otherwise stated in the Plan, which are in excess of the Deductible. For each Covered Person, the benefits payable in all Benefit Periods shall not exceed the Maximum Lifetime Benefit shown on the Schedule of Benefits.

When the members of a family unit have satisfied three times the individual calendar year deductible, no further deductible will be required of that family unit during that calendar year.

Eligible Expenses incurred during the last three (3) months of a calendar year that were applied to the Deductible shall also be applied to the Deductible for the next succeeding calendar year.
SECTION 5. COVERED MAJOR MEDICAL EXPENSES

COVERED EXPENSES

In order to be considered, expenses must be incurred by a Covered Person while the Plan is in force and be the result of an Injury incurred or an Illness which began while the Plan was in effect, and which meets all of the following requirements:

1. Must be related to treatment administered or ordered by a Physician or eligible provider;
2. Must be Medically Necessary for the diagnosis and treatment of an Illness or Injury;
3. Must not be excluded under any provision or section of the Plan;
4. Must be limited to the Usual, Reasonable and Customary Charge.

An expense will not be considered under more than one provision of the Plan.

Covered Expenses include the following:

1. Charges made by a Hospital for:
   a. Daily room and board, general nursing services, or confinement in an Intensive Care Unit not to exceed the Usual, Reasonable & Customary room charge;
   b. Necessary services and supplies other than room and board furnished by the Hospital will include inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions, emergency room use, physical therapy treatments, hemodialysis, x-ray and linear therapy.

2. Inpatient services in connection with Behavioral Health and Substance Abuse will be treated as an Illness.

3. Charges made by a Convalescent Hospital/Extended Care Facility for services and supplies furnished by the facility during any one convalescent period. Charges must commence within five (5) days following a Hospital Confinement of at least three (3) consecutive days and be for the same purpose and cause which created the Hospital Confinement. The confinement may not be for routine custodial care and the patient must be personally visited at least once each thirty (30) days by a Physician. These expenses include:
   a. Room and board, including any charge made by the facility as a condition of occupancy such as general nursing services. If private room accommodations are used, the daily room and board charge allowed will not exceed the facility's average semi-private charges, or an average semi-private rate made by a representative cross section of similar institution in the area;
   b. Medical services customarily provided by the Convalescent Hospital/Extended Care Facility except for private duty or special nursing services and Physician's fees;
c. Drugs, biologicals, solutions, dressings and casts furnished for use during the convalescent period, but no other supplies.

4. Charges related to a Hospice:
   a. Nursing care by a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), a vocational nurse or a public health nurse who is under the direct supervision of a Registered Nurse (R.N.);
   b. Physical therapy and speech therapy when rendered by a licensed therapist;
   c. Medical supplies, including drugs and biologicals and the use of medical appliances;
   d. Physician's services;
   e. Services, supplies and treatments ordered by a Physician.

5. Physician services for medical care and/or surgical treatments including office and home visits, Hospital inpatient care, Hospital outpatient visits/exams, clinic care, and surgical opinion consultations.

6. Registered Nurses (R.N.) or Licensed Practical Nurses (L.P.N.) for private duty nursing services, treatment by a licensed physiotherapist or registered kinesiotherapist. Fees will not be paid to a nurse, physiotherapist or registered kinesiotherapist who ordinarily resides in the same household or is the Covered Person's spouse, child, parent, brother or sister.

7. Treatment or services by a licensed physical therapist or registered kinesiotherapist in a home setting or at a facility or institution for which the primary purpose is to provide medical care for an Illness or Injury.

8. Services of a Physician or qualified speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to an Illness, Injury, other than a functional disorder, or due to surgery performed on account of an Illness or Injury.

   If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.

9. Medically Necessary Transportation of the Covered Persons by professional ambulance service, railroad, or regularly scheduled airline to the nearest Hospital or sanitarium equipped to furnish treatment for the Injury or Illness, provided that the Covered Person's Injury or Illness cannot be adequately treated in the locale where the Injury or Illness occurs.

10. Drugs that require a written prescription from a licensed Physician and are necessary for treating a covered Illness or Injury.

11. X-rays, microscopic tests, and laboratory tests.

12. Radiation therapy or treatment.

13. Charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if replaced.
14. Oxygen and other gases and their administration.

15. Electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.

16. Anesthetic cost and administration.

17. Dressings, sutures, casts, splints, trusses, crutches, braces, or other necessary medical supplies, with the exception of dental braces or corrective shoes.

18. Rental of a wheelchair, hospital bed or iron lung or other Durable Medical Equipment required for temporary therapeutic use of, at the option of the Plan Administrator, the purchase of such equipment.

19. Artificial limbs, eyes, larynx, and orthotic appliances. Replacement thereof is limited to reasons of growth of a covered Child, atrophy or additional surgery.

20. Voluntary sterilization.

21. Charges for treatment by an Ambulatory Surgical Center or minor emergency medical clinic.

22. Home Health Care Agency charges for care in accordance with a Home Health Care Plan. The Home Health Care Plan must commence within seven (7) days following a Hospital Confinement, and be for the same purpose and cause which created the Hospital Confinement. Such expenses include:
   a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or a vocational or public health nurse who is under the direct supervision of a Registered Nurse;
   b. Medical supplies, drugs, medicines and laboratory services prescribed by a Physician to the extent that they would have been covered under the plan if the Covered Person has remained in the Hospital.

Specifically excluded from coverage under the Home Health Care Plan are the following:
   a. Services and supplies not included in the Home Health Care Plan;
   b. Services of a person who ordinarily resides in the same household or is the Covered Person's spouse, child, parent, brother or sister;
   c. Services of a social worker;
   d. Transportation services;
   e. Meals and custodial care.

23. Chiropractic services may be covered only if all of the following requirements are met:
   a. The treatment is within the scope of a duly licensed chiropractor;
   b. The service would be covered by this Plan if it had been rendered by a Physician;
c. The treatment is Medically Necessary as indicated for the diagnosis;
d. The treatment is rehabilitative and not considered preventive or maintenance;
e. The frequency and/or duration of services is consistent with the diagnosis.

24. Insulin and necessary supplies used for the administration thereof.

25. Wellness Benefits are covered. The plan will allow for the following physical exam charges.
   a. Doctor's charges;
   b. Any test performed, including X-ray and lab charges;
   c. Charges for immunizations.

26. Any Covered Person who is receiving benefits under this Plan in connection with a mastectomy and who elects breast reconstruction, the following procedures will be covered under the Plan, subject to the usual co-payment and deductible requirements:
   a. Reconstruction of the break on which the mastectomy was prepared;
   b. Surgery and reconstruction of the other breast a symmetrical appearance; and
   c. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

27. Hospital expenses for mothers of newborn children who are covered under this Plan shall be covered for a minimum of two (2) days following a normal delivery and a minimum of four (4) days following a caesarian delivery. No pre-certification is needed for coverage not in excess of the two (2) and four (4) day limitations. An attending provider, after consulting with the mother, may discharge the mother and/or newborn before the two (2) and four (4) day periods mentioned above.

28. For purposes of the above paragraph, “attending provider: means an individual who is licensed under applicable state law to provide maternity or pediatric care and who is directly responsible for providing maternity or pediatric care to a mother or newborn child. Therefore, a plan, hospital, managed care organization, or other issuer is not an attending provider.

29. Off-Label Drug Use may be considered as a Covered Expense when all of the following additional criteria have been satisfied:
   a. The drug is not excluded under the Plan; and
   b. The drug has been approved by the FDA; and
   c. The Plan can demonstrate that the Off-Label Drug Use is appropriate and generally accepted for the condition being treated; and
   d. If the drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information or The Compendia-Based Drug Bulletin, recognized it as an appropriate treatment for that form of cancer.

28. Services and supplies in connection with covered transplant procedures, subject to the following conditions:
a. A Second Surgical Opinion must be obtained prior to undergoing any covered transplant procedure. This mandatory Second Surgical Opinion must concur with the attending Physician’s findings regarding the procedure being Medically Necessary. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training, or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery;

b. If the recipient is covered under this Plan, Eligible Expenses incurred by the recipient will be considered for benefits. In no event will benefits be payable in excess of the Maximum Benefit still available to the recipient;

c. If both the donor and the recipient are covered under this Plan, Eligible Expenses incurred by each person will be treated separately for each person;

d. The Usual, Reasonable and Customary Charge of securing an organ from a cadaver or tissue bank, including the surgeon’s charge for removal of the organ and a Hospital charge for storage or transportation of the organ, will be considered a Covered Expense.
SECTION 6. PLAN EXCLUSIONS

Notwithstanding any provision of this Plan to the contrary, the following exclusions apply to any expense or charge otherwise payable under this plan:

1. Charges for the part of an expense for care and treatment of an Injury Sickness that is in excess of the Usual, Reasonable and Customary Charge.

2. Charges incurred prior to the Covered Person's Effective Date of coverage under the Plan, or after such coverage is terminated.

3. Charges incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country.

4. Charges arising out of or in the course of employment for wage or profit except agricultural employment, whether such employment is with the Employer, with another employer, self-employment, or for which the Covered Person is entitled to benefits under any Worker's Compensation of Occupational Disease Law, or any such similar law.

5. Charges incurred while confined in a Hospital owned or operated by the United States Government or any agency thereof, or charges for services, treatments or supplies furnished by the United States Government or any agency thereof.

6. Charges incurred for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

7. Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act or assault; whether or not a criminal conviction is entered, provided that it is established by the Plan Administrator by a preponderance of the evidence that a crime was committed;

8. Charges incurred in connection with any intentionally self-inflicted Injury or Illness.

9. Charges incurred for nutritional supplements or vitamins.

10. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, nonprescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.

11. Charges for any treatment for cosmetic purposes or for cosmetic surgery are excluded, except that the Plan will pay for cosmetic treatment or surgery:

   a. needed solely as a result of an accidental bodily injury, but only if such treatment is rendered or surgery is performed within 12 months after the date the injury was sustained; or

   b. which is reconstructive surgery needed as a result of previous surgery performed to treat an illness; or
c. needed solely to correct a birth defect of a covered dependent child under 2 years of age.

EXCEPT THAT, charges for cleft lip and cleft palate birth defects in newborn children are covered if the newborn child had coverage at the time of birth.

12. Charges incurred in connection with services and supplies which are not Medically Necessary for the treatment of an Injury or Illness, or are in excess of Usual, Reasonable and Customary Charges, or are not recommended and approved by a Physician.

13. Charges incurred for services or supplies which are Experimental or Investigational (as defined herein);

14. Charges for elective abortions; unless the Physician certifies in writing that the pregnancy would endanger life of mother, or expenses are to treat medical complications due to non-elective abortions.

15. Charges for services rendered by a Physician, nurse, or licensed therapist who is the Covered Person's spouse, child, parent, brother or sister, or resides in the same household as the Covered Person.

16. Charges incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining medical service, drugs, or supplies.

17. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care.

18. Charges for room and board incurred in connection with a Hospital admittance on Friday or Saturday unless the attending Physician states in writing that such admittance was an emergency Hospital admittance and was Medically Necessary.

19. Charges for Physician's fees for any treatment which is not rendered by or provided under the supervision of a Physician.

20. Any surgical procedure for the correction of a visual refractive problem, including radial keratotomy.

21. Charges incurred for treatment of or to the teeth, nerves, roots, gingival tissue or alveolar processes. However, benefits will be payable for charges incurred: (1) for the removal of impacted teeth (no allowance for other extractions) on an Outpatient basis, unless Hospital Confinement is deemed to be Medically Necessary, and (2) for treatment required because of Injury to natural sound teeth sustained while covered. Item (2) of this exception shall not in any event be deemed to include charges for treatment for the repair or replacement of a denture.

22. Charges related to sex transformation or sexual dysfunctions or inadequacies.

23. Charges related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility or reverse sterilization, including, but not limited to artificial insemination, or in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, zona drilling, any other surgical or non surgical procedures or monitoring services (such as ultrasound or lab test) when related to treatment performed.
24. Charges for callus or corn paring or excision; any manipulative procedure for weak or fallen arches, flat or pronated foot, or foot strain, except for open cutting operations.

25. Charges for Custodial Care.

26. Charges for marital and family counseling.

27. Charges for Court Ordered Treatment.

28. Charges for the Hepatitis B vaccine and associated office visit will be covered under the medical plan for children under the age of 7.

29. Charges for treatment of any mental health condition or learning disability not contained in the Diagnosis Statistical Manual of Mental Disorders-IV; except that any learning disability which is required by state or federal law, regulation or rule shall be excluded if any public or private school or other learning facility is required under any such law, regulation or rule to provide either diagnosis or coverage for said learning disability;

30. Charges incurred which result from: 1) the voluntary taking of drugs except those taken as prescribed by a Physician, 2) the voluntary taking of poison, 3) the voluntary inhaling of gas, or 4) being under the influence of alcohol. A person will automatically be considered under the influence of alcohol while the level of their blood alcohol exceeds the legal limit of operating a motor vehicle in the jurisdiction where the injury occurred, regardless of whether the individual is charged with a crime if the Plan Administrator determines by a preponderance of the evidence, that the person was intoxicated.

Notwithstanding any provision in this Section 6 to the contrary, no exclusion based on the source of an Illness or Injury shall be enforceable if the Illness or Injury results from a medical condition (either physical or mental) or results from domestic violence.
SECTION 7. PLAN LIMITATIONS

Notwithstanding any provision of this Plan to the contrary, the following limitations apply to any expense or charge otherwise payable under this Plan.

HOME HEALTH CARE

Home health care visits shall be limited to a maximum of 40 visits in any calendar year, not to exceed four (4) hours per visit.

EXTENDED CARE FACILITY

Benefits payable will not be more than 50% of actual room charge of the Hospital in which Covered Person was confined before the extended care confinement; a maximum of 120 days per calendar year.

OBESITY

Charges for weight control or obesity, including diet control, diet supplements and physician approved weight loss clinics are not covered except for the medical treatment of obesity which is a direct and immediate threat to life. An individual is Morbidly Obese if that individual's weight is in excess of 170% of standard weight tables.

WIG

Charges up to $300 for one wig per lifetime if the wig is necessitated by treatment which rendered the patient bald.

HEARING AIDS

Charges for hearing aids to a $1,800 limit per ear with replacement once every 36 months.

REPLACEMENT OF ORGANS OR TISSUE

Charges due to tissue transplants, organ transplants, or replacement of tissue or organs with natural or artificial replacement materials or devices, and all charges due to complications arising from such procedures or treatment will be covered as follows:

1. The following procedures are payable on the same basis as any other Illness:
   a. Cornea Transplants
   b. Artery or Vein Transplants
   c. Kidney Transplants
   d. Joint Replacements
   e. Heart Valve Replacements
   f. Implantable Prosthetic Lenses in Connection with Cataracts
   g. Prosthetic By-pass or Replacement Vessels
   h. Bone Marrow Transplants
   i. Heart Transplants
   j. Lung Transplants
   k. Liver Transplants

2. No other replacement of tissue or organs are covered.
SECTION 8. PRESCRIPTION DRUG PROGRAM

All prescription drugs are exclusively dispensed through the Prescription Drug Program. Such drugs are not otherwise covered under the Comprehensive Medical Benefits portion of this Plan unless such prescription drugs are taken or administered to a participant, in whole or part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals. In this case, the drugs dispensed would be paid through the Comprehensive Medical Benefits portion of this Plan.

All drugs dispensed under the Drug Program must be:

1. Approved by the Food and Drug Administration;
2. Require a written prescription;
3. Dispensed by a licensed pharmacist or a doctor affiliated with the Prescription Drug Program.
4. Medically necessary and for the treatment of an Injury or Illness.

Under the Prescription Drug Program, the participant is required to pay a co-payment, for both generic and brand-named drugs, to a participating pharmacy for each dosage normally prescribed by a doctor no to exceed a 34 day supply for a retail prescription and a 90 day supply for a mail order prescription.

Generic substitution is automatic unless prohibited by the prescribing physician. However, if the prescribing physician does not prohibit generic substitution and the participant demands brand-name drugs be dispensed, then the participant will pay for the cost of the prescription, less the co-payment, up to the maximum allowable cost (the cost of the generic equivalent).

COVERED DRUGS AND MEDICATIONS INCLUDE:

1. Insulin on prescription and disposable needles / syringes used for the injection of insulin.
2. Diabetic testing agents and lancets.
3. Ostomy supplies.
5. Prescription drugs, subject to the exclusions listed below.
6. Any drug which under the applicable State law may only be dispensed upon the written prescription of a doctor or other lawful prescriber, subject to the exclusions listed below.

EXCLUSIONS

In addition to the Exclusions listed in Section 6, the following exclusions will apply to Prescription Drug Benefits:

1. Non-prescription drugs other than insulin.
2. Therapeutic devices or appliances, including support garments and other non-medical substances. Hypodermic needles and syringes except in conjunction with insulin.
3. Prescriptions which an eligible person is entitled to receive without charge from any Worker’s Compensation Laws.

4. Drugs labeled “Caution – Limited by Federal law to investigational use;”, or experimental drugs, even though a prescription or charge is made to the participant.

5. Charges for the administration or injection of any drug.

6. Anorectics (any drug for the purpose of weight loss).

7. Levonorgestrol (Norplant).


9. Medication which is to be taken by or administered to a participant, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

10. Any prescription filled in excess of the number specified by the doctor, or any refill in excess of the number specified by the doctor, or any refill dispensed after one year from the doctor’s original order.

11. Minoxidil (Rogaine) or any other drug for cosmetic purposes or treatment of alopecia.


Note: The above-listed drugs, covered and excluded, are not all inclusive. Other plan provisions may apply.

MAIL ORDER PRESCRIPTION DRUG PROGRAM

Benefits are paid for prescription drugs to a maximum of a 90 day supply through the mail order Drug Plan.

“Prescription maintenance drugs” means drugs prescribed by a doctor for chronic, degenerative health conditions.

A Covered Person must mail:

1. the original prescription;

2. a completed order form; and

3. the co-payment.

The Mail Order Drug Pharmacist will process and mail the prescription, a patient counseling message, and a replacement order form to the home or other designated location by first class mail or UPS.

THE BENEFIT PERCENTAGE AND CO-PAYMENT ARE SHOWN ON THE SCHEDULE OF BENEFITS.
SECTION 9. DENTAL EXPENSE BENEFITS

Benefits will be paid based on the benefit percentage and deductible, if an insured individual has covered dental charges. The amount paid will not be more than the Maximum Benefit in any one calendar year.

The charge for a dental procedure is deemed to have been incurred on the day of performance of the procedure. If a procedure is not completed in one day, the day on which the procedure is completed is deemed to be the incurred date for any charges in connection with such procedure.

COVERED DENTAL EXPENSES

When there is more than one method of satisfactory treatment, the Covered Dental Expenses will not exceed the reasonable and customary charges for the services and supplies which are customarily employed nationwide in the treatment of the disease or injury and which are recognized by the profession to be appropriate methods of treatment in accordance with broadly accepted nationwide standards of dental practice, taking into account the total current oral condition of the individual.

Charges of a legally qualified dentist are covered Dental Expenses as shown in the Schedule of Benefits.

WHAT THE DENTAL PLAN DOES NOT COVER

In addition to the Exclusions listed in Section 6, the following exclusions will apply to Dental Expense Benefits:

Expenses in connection with the following are not Covered Dental Expenses:

The following Charges of a legally qualified dentist are not Covered Dental Expenses as shown in the Schedule of Benefits.

1. Any service rendered before coverage on account of the person who received such services became effective.
2. Treatment other than by a licensed dentist or licensed physician, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by the dentist.
3. Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
4. Replacement of lost, missing or stolen prosthetic device.
5. Any services which are covered by any workman’s compensation laws or employer’s liability laws, or services which an employer is required by law to furnish in whole or in part.
7. Services rendered through a medical department, clinic or similar facility provided or maintained by the patient’s employer.
8. Services or supplies for which no charge is made that the covered person is legally obligated to pay or for which no coverage would be made in the absence of dental expense coverage.

9.1
9. Services or supplies which are not necessary, according to accepted standards of dental practice.

10. Services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature.

11. Services or supplies received as a result of dental disease, defect of injury due to an act of war, declared or undeclared.

12. Any duplicate prosthetic device or any other duplicate appliance.


15. Periodontal splinting.

16. Services to the extent that such services, or benefits for or because of such services, are otherwise provided under the Plan or under any other Plan which the employer (or any company subsidiary to or affiliated with the Employer) contributes to or otherwise sponsors.

17. Myofunctional therapy, or correction of harmful habits.

18. Expenses for services other than those specifically indicated as coverage.

**PREDETERMINATION OF BENEFITS**

Predetermination allows you to know what services are covered and what payments will be made for treatment performed before the work is done. If you or one of your family are likely to incur dental expenses over $200 (such as expenses for dentures, crowns, root canal therapy), you should ask your dentist to file for Predetermination of Benefits. This feature of the Dental Insurance Plan assures that both you and the dentist will know in advance just what part of the dentist’s charges the Plan will pay. Here is how it works:

1. If your dentist submitted a treatment plan for Predetermination of Benefits and then alters the course of treatment, the Administrator will adjust its payments accordingly. If the dentist makes a major change in the treatment plan, the dentist should send in a revised plan.

2. This predetermination requirement will not apply to courses of treatment under $200 or to emergency treatment, routine oral examination, X-rays, prophylaxis and fluoride treatments.

If you do not request Predetermination of Benefits, the Administrator will pay the claim based on whatever information it has about your case. Predetermination of Benefits could save you money (see section on Alternate Procedures).

If your dentist submitted a treatment plan for Predetermination of Benefits and then alters the course of treatment, the Administrator will adjust its payments accordingly. If the dentist makes a major change in the treatment plan, the dentist should send in a revised plan.

This predetermination requirement will not apply to courses of treatment under $200 or to emergency treatment, routine oral examination, X-rays, prophylaxis and fluoride treatments.
SECTION 10. VISION EXPENSE BENEFITS

Vision-care benefits payable are 100% of the Maximum Benefit shown on the Schedule of Benefits section, to the extent that such charges are Reasonable and Customary for the area and product or type of service. The Vision Care Maximum Payment during each calendar year for each individual covered shall not exceed the maximum payment applicable to the treatment or service rendered.

The term “Complete Visual Analysis” means refraction and eye examination, including case history; examination for disease or pathological abnormalities of the eyes and lids; ranges of clear single vision; balance and coordination of muscles for far seeing, near seeing, and special working distances analysis; and professional consultation.

EXCLUSIONS

In addition to the Exclusions listed in Section 6, the following exclusions will apply to Vision Expense Benefits:

Benefits will not be paid for:

1. Accidental bodily injury or sickness that arises out of or occurs in the course of any occupation or employment for wage or profit.

2. Services, supplies, or treatment provided by or covered by (1) the United States Government under any plan or law, or (2) any state, province, or political subdivision; and (3) any hospital or institution that does not require the individual to pay for such expenses in the absence of insurance.

3. Exams that are not performed by a doctor.

4. Supplies that are not prescribed by a doctor.

5. Charges for services or supplies that are covered under any other provision of the policy.

6. Special procedures, such as orthotics, vision training, or subnormal-vision aids.

7. Plain or prescription sunglasses or other special-purpose vision aids.

8. Medical or surgical care of the eyes.

9. Replacement of lost or broken lenses and/or frames.

10. Duplicate glasses, lenses, or frames.

11. Services or material not listed in the Schedule of Vision Expense Benefits,
SECTION 11. COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed expenses. It applies when the Employee or any eligible dependent who is covered by this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plan pays a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. Only the amount paid by the Plan will be charged against the Plan maximums.

DEFINITIONS

Allowed expense: The reasonable and customary expense for medical or dental care or treatment. Part of the expenses must be covered under at least one of the plans covering a covered employee or dependent.

Coordination of benefits: The way benefits are payable under more than one health plan. Under coordination of benefits, a covered employee or dependent will not receive more than the allowed expenses for a loss.

Plan: Any of the following providing medical or dental benefits or services:

1. This Plan.
2. Any group, blanket or franchise health insurance.
3. A group contractual prepayment or indemnity plan.
4. A Health Maintenance Organization (HMO), whether group practice or individual practice association.
5. A labor-management trusteed plan or a union welfare plan.
6. An employer or multi-employer plan or employee benefit plan.
7. A government program. (Excluding Medicaid)
8. Insurance required or provided by statute.
9. Any coverage for students which is sponsored by, or provided through a school or other educational institution.

Plan does not include any individual or family policies or contracts or public medical assistance programs, including Medicaid.

Note: In the case of HMO (Health Maintenance Organization), PPO (Preferred Provider Organization), EPO (Exclusive Provider Organization) plans: This plan will not consider any charges in excess of what an HMO/PPO/EPO provider has agreed to accept as payment in full. Also, when an HMO/PPO/EPO pays its benefits first, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO/PPO/EPO had the Covered Person used the services of an HMO/PPO/EPO provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.
Primary plan/
secondary plan: When this Plan is primary, its benefits are determined before those of the other plan. The benefits of the other plan are not considered. When this Plan is secondary, its benefits are determined after those of the other plan. Its benefits may be reduced because of the other plan's benefits. When there are more than two plans this Plan may be primary as to one and may be secondary as to another.

ORDER OF DETERMINATION

This Plan determines its order of benefits using the first of the following which applies:

1. General - A plan that does not coordinate with other plans is always the primary plan.

2. Non-dependent/Dependent - The benefits of the plan which covers the person as an employee or member (other than a dependent) is the primary plan; the plan which covers the person as a dependent is the secondary plan.

3. Dependent Child/Parent Not Separated or Divorced - Except as stated in (4) below, when this Plan and another plan cover the same child as a dependent of different parents:
   a. The primary plan is the plan of the parent whose birthday (month and day) falls earlier in the year. The secondary plan is the plan of the parent whose birthday falls later in the year, but
   b. If both parents have the same birthday, the benefits of the plan which covered the parent the longer is the primary plan; the plan which covered the parent the shorter time is the secondary plan.
   c. If the other plan does not have the same birthday rule, but has the gender rule and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. Dependent Child/Separated or Divorced Parents - If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order.
   If the specific terms of a court decree state that one parent is responsible for the health care expense of the child, then that parent's plan is the primary plan, otherwise, the following will be the order of determination:
   a. the plan of the parent with custody of the child;
   b. the plan of the spouse of the parent with custody;
   c. the plan of the parent without custody of the child.

5. Active/Inactive Employee - The primary plan is the plan which covers the person as an employee who is not laid off, retired or a COBRA continuee (or as that employee's dependent). The secondary plan is the plan which covers that person as a laid off, retired employee or COBRA continuee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
Order of Determination (Cont'd)

6. Longer/Shorter Length of Coverage - If none of the above rules determines the order of benefits, the primary plan is the plan which covered an employee or member longer. The secondary plan is the plan which covered that person the shorter time.

MEDICARE

Any benefits covered under both this Plan and Medicare will be paid pursuant to Medicare Secondary Payer legislation, regulations, and Health Care Financing Administration guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Plan provisions, and federal law.

RETIRED MEMBERS 65 AND OVER, END STAGE RENAL MEMBERS & DISABLED MEMBERS ENTITLED TO MEDICARE

The Plan will calculate benefits as follows: Except when federal law requires the Plan to be the primary payor, the benefits under this Plan for Retired Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, we will calculate benefits as if they had enrolled.
SECTION 12. UTILIZATION REVIEW

Utilization Review is a program which reviews the setting, necessity and quality of health care. The Plan furnishes each participant with Utilization Review through a Review Agent. The Covered Person is responsible for making sure the Review Agent is contacted. Authorization from the Review Agent is required for:

1. Inpatient Hospital Stays;
2. Skilled Nursing;
3. or Other Inpatient Facility

Utilization Review is performed only for the purpose of reviewing the medical necessity of the above services for the care and treatment of an illness. Authorization by the Review Agent does not guarantee that all charges are covered under this Plan. Charges submitted for payment are subject to all other terms and conditions of the Plan.

FAILURE TO CALL PENALTY

If the Covered Person fails to call the Review Agent as required under Certification/Pre-Certification below, a penalty will apply. This penalty deductible is in addition to any other deductible or co-pay under the Plan.

IF HOSPITAL UTILIZATION REVIEW IS NOT USED BY THE INSURED INDIVIDUAL, THE FOLLOWING APPLIES

1. If hospital charges are incurred by an insured individual for a period of hospital confinement as a bed patient for which benefits have not been authorized by the Review Agent, as set out under Hospital Pre-Admission Review, above, the eligible charges for such confinement will be limited to 50% of the eligible charges had the Hospital Pre-Admission Review been performed, to a maximum penalty of $500.
2. Hospital charges incurred by a Covered Person for the part of a Hospital Confinement which was not authorized by the Review Agent shall not be considered to be Eligible Expenses. For example, if Pre-Admission Review and Concurrent Review Authorize three (3) days and the covered Person stays in the hospital for four (4) days, the additional day's charges will not be covered by the Plan.

CERTIFICATION/PRE-CERTIFICATION

1. Hospital Admissions:

   The Covered Person is responsible for making sure that the Review Agent is notified of the hospital stay before admission to a hospital as a bed patient. The Review Agent will review the Physician's recommendation to determine whether a hospital stay is necessary or if the procedure can be safely performed on an outpatient basis. If authorization for hospital admission is denied, no benefits will be paid for hospital charges.

2. Emergency/Urgent/Pregnancy Related/Hospital Admission:
For an emergency or urgent hospital admission (including all pregnancy related events), the Covered Person is responsible for making sure the Review Agent is notified within 48 hours after admission. For admission on a holiday or after business hours, the Review Agent must be informed of the admission on the next business day. Benefits will be paid for authorized days only.

"Emergency hospital admission" means an admission for hospital confinement, which, if delayed would result in a disability or death.

"Urgent hospital admission" means admission for a medical condition resulting from injury or illness which is less severe than an emergency admission but requires care within a reasonably short time. This includes pregnancy related events.

CONCURRENT REVIEW

After admission to the hospital, the Review Agent will continue to evaluate the patient's progress. If, after consulting with the Physician, the Review Agent determines that continued confinement is no longer medically necessary, the Covered Person and the Physician will be advised. Benefits will be paid only for authorized days. No benefits will be paid for hospital days not authorized.

The Review Agent will also evaluate the patient's progress under authorized healthcare services and supplies review. If, after consulting with the Physician, the Review Agent determines that continued treatment is no longer medically necessary, the Covered Person and the Physician will be advised. Benefits will be paid only for authorized treatment and services. No benefits will be paid for treatment and services not authorized.
SECTION 13. LARGE CLAIM MANAGEMENT

The Plan Administrator may, at its option, provide a Large Case Management program to assist the participant in obtaining needed medical care from the most appropriate source available. The Large Case Manager will have the option of suggesting methods and providers of care which may not be specifically covered by this Plan. The costs of these special care facilities and treatment will be covered as any other expense under this Plan.

Large Case Management is a voluntary program. It is designed to provide and promote an individualized program of care outside of the acute care Hospital setting to a Covered Person suffering from catastrophic Illness or Injury. These conditions include, but are not limited to:

1. terminal stage cancer, brain tumors, organic brain damage;
2. coronary heart disease, heart attack or stroke;
3. head injuries, skull fracture, fracture of neck and/or trunk, spinal cord injury;
4. neonatal conditions, prematurity, infantile cerebral palsy, and respiratory distress syndrome;
5. AIDS;
6. transplants.

Each case receives individual and ongoing attention. The Case Manager does not prescribe care, but works to coordinate viable care alternatives. The Case Manager consults with the patient, the family, the attending Physician and the Hospital in order to develop a plan of care for approval by the patient’s attending Physician and the patient. This plan of care may include some or all of the following:

1. personal support to the patient;
2. contacting the family to offer assistance and support;
3. monitoring Hospital or nursing home care;
4. determining alternative care options such as Home Health Care, Hospice Care, or rehabilitative care; and
5. assisting in obtaining any necessary equipment and services.

Note: Large Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.
SECTION 14. CONTINUATION OF COVERAGE (COBRA)

INTRODUCTION

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under your group health insurance plan (“the Plan”). This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

For purposes of this Section, “gross misconduct” shall be determined by the Plan Administrator, on a nondiscriminatory basis, after considering the following circumstances:

1. Was conduct illegal and/or a violation of the Employer’s policies and procedures?
2. Was the conduct intentional?
3. Was the conduct disruptive or harmful to the employer’s business or the workplace?
4. Was the conduct the first disciplinary offense?
5. Was the conduct condoned or tolerated by the employer?
6. Are there mitigating circumstances involving the conduct?

Gross misconduct includes, but is not limited to, actions which deviate from the Employer’s policies and standards, regardless of whether or not the conduct constitutes a criminal offense. The fact that an Employee is offered to voluntarily resign because of any such conduct does not preclude the Plan Administrator from concluding that the Employee was terminated for “gross misconduct.” To the extent the conduct involved a criminal act, the fact that the Employer does not file the applicable charges with the local prosecutor does not preclude the Plan Administrator from determining that the conduct constituted “gross misconduct.”

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

1. Your spouse dies;
2. Your spouse’s hours of employment are reduced;
3. Your spouse’s employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.
Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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

WHEN IS COBRA COVERAGE AVAILABLE?

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

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days (review the COBRA Procedures in your SPD for specific rules) after the qualifying event occurs. You must provide this notice to:

EAST ALLEN COUNTY SCHOOLS
1240 St. Rd. 930 East
New Haven, IN 46774
Phone: (260) 446-0100

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Review the COBRA Procedures in your SPD for additional rules. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

**DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Review the COBRA Procedures in your SPD for additional rules.

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**IF YOU HAVE QUESTIONS**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

**KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES**

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

**PLAN CONTACT INFORMATION**

EAST ALLEN COUNTY SCHOOLS
1240 St. Rd. 930 East
New Haven, IN 46774
Phone: (260) 446-0100

14.3
COBRA PROCEDURES

A. Qualifying Event Involving Divorce or Loss of Dependent Status

1. Notification to Plan Administrator

Qualified beneficiaries who lose coverage (or will lose coverage) because of a divorce or legal separation or because a dependent no longer qualifies as a dependent as (defined in the Plan), must notify the Plan Administrator, in writing, via either facsimile or U.S. Mail of the qualified beneficiary's desire to extend COBRA coverage after the date of the divorce or loss of dependent status. Such notice must be sent to the following address:

EAST ALLEN COUNTY SCHOOLS
1240 St. Rd. 930 East
New Haven, IN 46774
Phone: (260) 446-0100

Notice may be made by the employee/former employee or any other qualified beneficiary that is a spouse or dependent of the former employee. Such notice may be given before the occurrence of the divorce or loss of dependent status, but must, in all cases, be given no later than sixty (60) days after the date of the divorce or the loss of dependent status. Oral notice or notice by e-mail is not sufficient under these Procedures.

2. Documents Required for Divorce/Separation

With respect to the information which must be given to the Plan Administrator, when divorce or legal separation is the qualifying event, the qualified beneficiary must provide the Plan Administrator with a copy of the Court Decree dissolving the marriage. If the divorce or legal separation has not yet been concluded, the qualified beneficiary must provide the Plan Administrator with any court documents that have been filed (such a Petition for Dissolution) and indicate the date that the divorce or legal separation is expected to be final.

3. Documents Required for Loss of Dependent Status

With respect to loss of dependent status, a qualified beneficiary must provide to the Plan Administrator the reason the individual will no longer qualify as a dependent

B. Qualifying Events Involving Termination, Reduction in Hours, Death and Bankruptcy - Notification by Plan Administrator

Qualified beneficiaries who lose coverage because of a termination, reduction in hours, death or bankruptcy will receive a COBRA Election form which permits the employee/former employee (and dependents) to elect coverage and indicates the premium for such coverage.

Election form shall be sent by U.S. Mail, postage pre-paid, to the last known address of the employee/former employee unless the Plan Administrator has been notified in writing to the contrary. The last known address shall be deemed to the most recent address contained in the employee/former employee's personnel file. In the event the employee/former employee changes address, it is his or her responsibility to notify
notify the Plan Administrator of any change in address and the Plan Administrator
shall not be responsible for notices sent to the wrong address if the more recent
address was not provided in the above manner. Notification to an employee/former
employee who elected spousal coverage shall be sent with an envelope marked “Mr.
and Mrs. John Smith.” Election forms sent to an employee/former employee that has
one or more children/dependents covered shall be addressed to the employee (if the
spouse was not covered) or to the employee and spouse (if spousal coverage was
elected), and each shall be deemed to include notification to any dependent children,
unless the Plan Administrator has actual knowledge of a different address for a
dependent child before the date the election form is mailed and provided further that
any such notification to the Plan Administrator was in writing sent via either U.S. Mail
or facsimile.

C. Errant Notices

In the event an individual receives a COBRA Election Form before the date the Plan
Administrator determines that the individual is not eligible to elect COBRA (either
because of an error concerning the individual’s eligibility or because the individual
was fired for gross misconduct), the Plan Administrator shall notify the individual of
the errant notice within fourteen (14) days of the date that the individual was originally
given the COBRA Election Form.

D. Early Termination of COBRA

In the event a qualified beneficiary’s COBRA coverage terminates before the duration
of COBRA coverage (either 18, 29 or 36 months after the qualifying event), the Plan
Administrator shall notify the qualified beneficiary of the early termination date and
the reason for early termination of COBRA coverage.

E. Postmark Date

All notifications, payments and other correspondence from a qualified beneficiary (or
a possible qualified beneficiary) shall be deemed to have been received on the date
that the item is postmarked, if sent by U.S. Mail. In the event communication or
correspondence is sent via facsimile, the communication or correspondence shall be
deemed to have been received on the date it is transmitted. All facsimile
transmissions must be sent to the facsimile number identified in paragraph A above.

F. Eleventh Month Disability Extension

COBRA continuees who are determined by Social Security to be disabled within the
first 60 days of COBRA continuation coverage (or earlier) may elect to extend the 18th
month COBRA period by eleven (11) months, provided the applicable premium is
paid. The eleven month extension will only be given if the Plan Administrator is
notified in writing, via either U.S. Mail or facsimile, of the Social Security
determination. This written notification must also contain a copy of the Social
Security determination. Qualified beneficiaries are required to request the eleven
month extension within 30 days of receiving the Social Security determination and, in
any event, must be provided to the Plan Administrator before the end of the 18 month
COBRA continuation period. Any qualified beneficiary not meeting each of these
rules will not be entitled to elect the eleven month extension. Qualified beneficiaries
who were originally determined to be disabled but had that determination reversed
must notify the Plan Administrator within 30 days of notification of the reversal. In the
event the qualified beneficiary does not notify the Plan Administrator of any such
reversal, the qualified beneficiary shall be required to repay the Plan for any claims
which were incurred after the date of reversal.
G. Multiple Qualifying Events

In the event a qualified beneficiary experiences a second qualifying event during the original 18 or 29 month period, who wishes to apply for an extension of the 18 or 29 months because of a second qualifying event, must notify the Plan Administrator via either U.S. Mail or facsimile, of the occurrence of the second qualifying event within 60 days after the event occurs. Any qualified beneficiary who fails to notify the Plan Administrator of the occurrence of the second qualifying event will not be entitled to extend coverage past the end of the 18 or 29 month period. COBRA coverage shall not extend beyond 36 months from the day of the original qualifying event, regardless of the occurrence of multiple qualifying events. Whether the subsequent qualifying event entitles a qualified beneficiary to extend coverage, under the applicable regulations, will be determined by the Plan Administrator.

H. Payment Requirements

COBRA payments must be paid monthly in the amount designated on the Election Form. The first COBRA payment is due within forty-five (45) days after the election form is executed. This payment covers the cost of the health care coverage provided from the date of the qualifying event (or loss of coverage, if later) through the date of the election. After the first payment, all subsequent COBRA payments are due on the first of each month for the applicable month. If no payment is received for a particular month, the qualified beneficiary shall be given a grace period of thirty (30) days to pay the premium.

All payments of COBRA premiums should be made by check, money order or cashier’s check. If payment is made by personal check, the qualified beneficiary shall be solely responsible for maintaining sufficient funds in his/her account so that the check will clear when presented. If a COBRA payment paid by personal check does not clear when first presented, the Plan Administrator shall make a second attempt to cash the check if the Plan Administrator has at least five (5) working days notice before the end of the thirty (30) day grace period. It is the obligation of the qualified beneficiary to confirm that his/her COBRA personal checks have cleared the bank. The Plan Administrator shall not be under any obligation to notify the qualified beneficiary if a check does not clear. Additionally, if the Plan Administrator is presented with a personal check that does not clear, the Plan Administrator shall have the option of requiring all subsequent COBRA payments to be made by guaranteed funds (i.e. money order or cashier’s check).

SUBSIDY INFORMATION UNDER THE AMERICAN RECOVERY AND REINVESTMENT ACT

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. ARRA made several amendments to these provisions, including an increase in the amount of the credit to 80% of premiums for coverage before January 1, 2011 and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered employees who have a nonforfeitable right to a benefit any portion of which is to be paid by the PBGC) and TAA-eligible individuals.
If you have any questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.
SECTION 15. THIRD PARTY RECOVERY PROVISION

SUBROGATION

When a Covered Person incurs expenses that were either the result of the alleged negligence, 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 Person by reason of their eligibility for benefits under the Plan, the Plan will advance benefits under the following terms and conditions:

The Covered Person will reimburse the Plan out of the Covered Person’s recovery for all benefits paid by the Plan. The Plan will be reimbursed in full prior to the Covered Person receiving any monies recovered from any party of their insurer as a result of judgment, settlement or otherwise. The duty and obligation to reimburse the Plan applies even if the Covered Person is not fully compensated (or “made-whole”) for their injuries and damages. The Plan shall have a property right in the form of a constructive trust in the proceeds of any settlement. The Covered Person and/or his legal representative shall hold the Plan’s interest in trust and shall distribute said interest on demand by the Plan. Furthermore, the Covered Person shall include the Plan’s name as a co-payee on any settlement check.

The Covered Person shall fully cooperate with the Plan in any case involving the alleged negligence of a third party. 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 section. In the event the Plan has reason to believe that the Plan may have a subrogation lien, the Plan may require the Covered Person to complete a subrogation questionnaire, sign an acknowledgement of the Plan’s subrogation rights and an agreement to provide ongoing information before the Plan pays, or continues payments of claims according to its terms and conditions. Upon receipt of the requested materials, the Plan will commence, or continue, payments of claims, according to its terms and conditions provided that said payment of claims in no way prejudices the Plan’s rights. Payment of claims before the signed forms are received does not modify or invalidate the Plan’s subrogation rights.

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 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.

In the event that the Plan Administrator determines that a subrogation recovery exists, the Plan Administrator retains the right to employ the services of any attorney to recover money due to the Plan. The Covered Person shall 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 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 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 shall not release any third party or their insurer without prior written approval from the Plan, and will take no action which prejudices the Plan’s subrogation right. If the Covered Person impairs the Plan’s subrogation right, or refuses to reimburse the Plan from any settlement or judgment received, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims of the Covered Person and to reduce future benefits payable under the Plan by the amount due as reimbursement by the Plan.

The Covered Person shall refrain from characterizing any settlement in any manner so as to avoid repayment of the Plan’s lien or right to reimbursement.
The Plan pays secondary to any and all PIP, Med-Pay or No-Fault coverage. The Plan has no duty or obligations 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 case of a Michigan insured that 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.

RIGHTS OF RECOVERY

In the event of any overpayment of benefits by this Plan, this Plan will have the right to recover the overpayment by requesting a refund or off-set future benefits. If a Covered Person is paid a benefit greater than allowed in accordance with the provisions of this Plan, the Plan with either request the Covered Person to refund the overpayment or the Plan will off-set future benefits. Similarly, if payment is made on the behalf of a Covered Person to a Hospital, Physician, or other provider of health care, and the payment is found to be an overpayment, the Plan will either request a refund of the overpayment from the provider or the Plan will off-set future benefits to the provider.

EXCESS COVERAGE

This provision applies when the participant incurs medical or dental charges for which the participant is eligible to receive medical or dental benefits from a policy of liability insurance, property insurance, casualty insurance or property-casualty insurance, including but not limited to:

1. motor vehicle policy;
2. homeowner’s policy;
3. renter’s insurance policy; or
4. boat owner’s policy
5. uninsured or underinsured motorist plan

When this happens, the Plan will pay the lessor of:

1. the benefits of this Plan; or
2. 100% of the charges eligible under this Plan for the medical or dental less the amount the participant is eligible to receive for the same charges from the liability insurance, property insurance, casualty insurance or property-casualty insurance.
SECTION 16. COMPLIANCE WITH FEDERAL LAWS

FAMILY AND MEDICAL LEAVE ACT OF 1993

In the event that the Employer approves a leave under the Family and Medical Leave Act of 1993 for an Eligible Employee, that Eligible Employee may receive up to twelve (12) work weeks of continued benefits under this Plan while on such leave (provided that required contributions, if any, are made by or on behalf of that Eligible Employee).

The Continuation of Coverage Provision (COBRA) outlined in the Plan will apply on the earliest of:

1. the date that the Eligible Employee informs the Employer of his intent not to return from such leave; or
2. the date that the Eligible Employee does not return from such leave and coverage for the Employee or Dependents would be lost were it not for COBRA coverage.
3. the date the Employee fails to make the necessary payment to continue coverage under this Plan as set forth in the Employer’s FMLA policy.

An Eligible Employee returning from an approved leave under the Family and Medical Leave Act, who did not continue benefits under this Plan during such leave, will not be required to satisfy a new waiting period or provide proof of good health upon returning to Actively at Work status and meeting the definition of an Eligible Employee. In addition, such persons will continue to be covered under the Plan as if there had been no break in service, and a new Pre-Existing Condition Limitation will not apply to such persons as long as the condition was covered prior to the approved leave.

AMERICANS WITH DISABILITIES ACT

The Plan has not been created to violate the Americans with Disabilities Act (ADA). Should it be determined that a provision could be in violation, the Plan shall be amended.

WOMEN’S HEALTH ACT AND CANCER RIGHTS ACT

Under the Federal Women’s Health and Cancer Rights Act of 1998, you are entitled to the following services:

1. reconstruction of the breast on which the mastectomy was preformed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema).

Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other illness.

NEWBORNS AND MOTHERS PROTECTION ACT

Group Health 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 48 hours following a vaginal delivery, or less than 96 hours following a cesarean 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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).
HIPAA PRIVACY RULES
Use and Disclosure of Protected Health Information

The Standards for Privacy of Individually Identifiable Health Information (“Privacy Standards”) promulgated under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) govern the Plan’s use and disclosure of protected health information (“PHI”).

Pursuant to the Privacy Standards, the Plan may:

1. Disclose PHI to the Plan Sponsor to carry out plan administration functions that the Plan Sponsor performs only in accordance with the Plan documents and the restrictions on uses and disclosures set forth herein;
2. Not permit a health insurance issuer or HMO with respect to the Plan to disclose PHI to the Plan Sponsor except as permitted by the Privacy Standards;
3. Not disclose and not permit a health insurance issuer or HMO to disclose PHI to the Plan Sponsor unless a statement permitting such disclosure is included in the applicable Notice of Privacy Practices; and
4. Not disclose PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor is permitted to use and disclose the PHI disclosed to it for all purposes required or permitted by the Privacy Standards, including (without implied limitation) treatment, payment and health care operations.

“Treatment” means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

“Payment” includes activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of Plan benefits or to provide reimbursement for the provision of health care that relates to an individual to whom health care is provided.

These activities include, but are not limited to, the following:

1. Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual’s claim);
2. Coordination of benefits;
3. Adjudication of health benefit claims (including appeals and other payment disputes);
4. Subrogation of health benefit claims;
5. Establishing employee contributions and COBRA premiums;
6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
7. Billing, collection activities and related health care data processing;
8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
9. Obtaining payment under a contract of reinsurance (including stop-loss and excess of loss insurance);
10. Medical necessity reviews or review of health care services for coverage under the plan, appropriateness of care or justification of charges;

11. Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

12. Disclosing the following information to consumer reporting agencies related to the collection of premiums or reimbursement: name, address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan; and

13. Reimbursement to the Plan.

Health Care Operations include, but are not limited to the following activities:

1. Quality assessment and improvement activities;

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions that do not include treatment;

3. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities,

4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including, but not limited to, formulary development and administration, development or improvement of payment methods or coverage policies;

7. Business management and general administrative activities of the Plan, including, but not limited to: (a) management activities relating to the implementation of and compliance with HIPAA’s administrative simplification requirements, (b) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers, (c) resolution of internal grievances, and (d) the sale, transfer, merger or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and

8. Creating de-identified health information or a limited data set.

Also as required by the Privacy Standards, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

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

3. Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual about whom the PHI relates;

4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual about whom the PHI relates;
5. Report to the Plan any PHI use or disclosure of which it becomes aware that is inconsistent with the permitted uses or disclosures;

6. Make PHI available to an individual in accordance with the Privacy Standards’ access requirements;

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with the requirements of the Privacy Standards;

8. Make available the information required to provide an accounting of disclosures in accordance with the requirements of the Privacy Standards;

9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining the Plan’ compliance with the Privacy Standards;

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

11. Ensure that the adequate separation required pursuant to the Privacy Standards, if any, is established.

In accordance with the Privacy Standards, the Plan Sponsor has determined that only the following employees or classes of employees need access to PHI in the ordinary course of business and to discharge their duties to the Plan Sponsor:

1. the benefits manager;

2. staff designated by the benefits manager;

3. the Privacy Officer;

4. the human resources manager.

Accordingly, only the foregoing employees or classes of employees may have access to PHI. Further, the foregoing employees or classes of employees may only have access to, and may only use and disclose PHI for, plan administration functions that the Plan Sponsor performs for the Plan.

If the foregoing employees do not comply with the provisions of this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

HIPAA SECURITY STANDARDS

1. Definitions:

   a. Electronic Protected Health Information. The term “Electronic Protected Health Information: has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

   b. Security Incidents. The term “Security Incidents: has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.
2. Plan Sponsor Obligations

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

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

b. Plan Sponsor shall insure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

c. Plan Sponsor shall insure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

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

   Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modifications, or destruction of the Plan’s Electronic Protected Health Information; and

   e. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan’s request.
SECTION 17. CLAIM FILING AND APPEAL PROCEDURES

The following Procedures explain various rules and time limitations for filing a claim for benefits under the East Allen County Schools Plan (“Plan”) and additional rules and time limitations for filing an appeal of a claim that is wholly or partially denied. For purposes of interpreting these Procedures, the following terms have the following meanings as those terms appear herein:

DEFINITIONS

CLAIM

A request for a specific medical treatment or, for treatment which has already been rendered, a request for payment for medical services provided. For purposes of these Procedures, any interaction between a Claimant and a preferred or network provider shall not be treated as a Claim if the medical provider exercises no discretion. Similarly, any reply to a request for a pre-certification which does not deny coverage (or limit coverage) for medical services is not considered a “Claim”. Additionally, a medical provider’s refusal to render services without payment by the patient is not considered a Claim subject to these Procedures. Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered a Claim subject to these Procedures. Notwithstanding the foregoing, any action or inaction by a provider that is not treated as a Claim for these purposes will be treated as a Claim and be reviewed by the appropriate person or entity if an individual files a specific request with the Plan that any action or inaction by the provider be treated as a Claim under Plan.

CLAIMANT

Any individual filing a claim under the Plan pursuant to those Procedures.

CONCURRENT CARE CLAIMS

A Claim for specific ongoing medical treatment of an Illness or Injury. Except as otherwise specifically noted, all time limitations and other rules and restrictions for Concurrent Care Claims are identical to those for Pre-Service Claims, unless the Concurrent Care Claim qualifies as an Urgent Care Claim, in which case the Urgent Care Claim time limitations apply.

ELECTRONIC NOTIFICATION

The transmission of Claim or medical information via email, fax or any other means other than the delivery of written information via first class mail. Any information transmitted pursuant to these Procedures via Electronic Notification must be resubmitted in writing, sent to the appropriate party via first class mail, within seventy-two (72) hours of the Electronic Notification.

PRE-SERVICE CLAIMS

A Claim for medical care that is required to obtain approval before obtaining care.

POST-SERVICE CLAIMS

A Claim for services already been rendered.

URGENT CARE CLAIMS

Those Claims where failing to make a determination (about eligibility, medical necessity, etc.) quickly could seriously jeopardize an individual’s life, health or ability to gain maximum function, or could subject the individual to severe pain that could not be managed without the requested treatment. Notwithstanding the preceding sentence, any Claim designated by the treating physician as in “Urgent Care Claim” will be treated as such for purposes of these Procedures.
INITIAL CLAIM FILING REQUIREMENTS

HOW TO FILE A CLAIM

All Claims must be filed with the PPO as designated on the Employee’s insurance card.

TIME LIMITS FOR FILING INITIAL CLAIMS

All Claims must be filed with the Third-Party Administrator within one (1) year after the expenses were incurred, unless the Claimant was legally incapacitated, in which case the Claim must be filed as soon as reasonably possible after such incapacitation ends.

TIME LIMITS FOR REVIEW OF INITIAL CLAIMS

The Third-Party Administrator shall review and process the following types of Claims within the following time limitations:

Urgent Care Claims – Initial determinations on Claims considered Urgent Care Claims shall be made as soon as possible but no later than 72 hours after it is received. Initial determinations on Concurrent Care Claims which qualify as Urgent Care Claims shall be made within twenty-four (24) hours after the Claim is received.

Pre-Service Claims – Initial determinations shall be made within fifteen (15) days of the time the Claim is received. This time limitation may be extended by up to fifteen (15) days if the Third-Party Administrator determines that additional time is necessary due to matters outside the control of the Third-Party Administrator.

Post-Service Claims – Initial determinations shall be made within thirty (30) days from the date the Claim is received. This time limitation may be extended by up to fifteen (15) days if the Third-Party Administrator determines that additional time is necessary due to matters outside the control of the Third-Party Administrator.

Incomplete Claims – For any Claim which does not provide information necessary for the Third-Party Administrator to make the initial determination, the Claimant will be notified that additional information is needed within twenty-four (24) hours for Urgent Care Claims, and within five (5) days for Pre-Service Claims. After receiving notification, the Claimant must provide the missing information within forty-eight (48) hours for Urgent Health Care Claims and within forty-five (45) days for Pre-Service and Post-Service Claims. Failure to provide the missing information within the time deadlines specified shall result in the Claim being denied.

RESPONSE TO CLAIM

If an individual’s Claim for benefits is wholly or partially denied, any notice of such adverse benefit determination under the Plan will:

a. State the specific reason(s) for the denial or partial denial;
b. Reference the specific plan provisions on which the determination was based;
c. Describe additional material or information necessary to complete the claim and why such information is necessary;
d. Describe Plan procedures and time limits for appealing the determination (as set forth below) and the right to obtain information about those procedures and the right to sue in federal court; and
e. Disclose any internal rule, guidelines, protocol or similar criteria relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of any adverse determination may be provided by the Plan via written or Electronic Notification, provided that an Electronic Notification will be sent via first class mail within seventy-two hours from the date it is originally received.

APPEAL PROCEDURES

HOW TO FILE AN APPEAL

In the event an individual’s Claim is wholly or partially denied, the individual has the right to appeal to the Plan for review of the Claim. All appeals will be decided by the Plan Administrator, as defined in the summary plan description. Appeals may be made via Electronic Notification by contacting the Plan Administrator, but any appeal in Electronic form must be sent in writing within seventy-two (72) hours via first class mail to the Plan Administrator at the following address:

EAST ALLEN COUNTY SCHOOLS
1240 St. Rd. 930 East
New Haven, IN 46774
Phone: (260) 446-0100

TIME LIMITATION FOR FILING APPEAL

All Claims which are wholly or partially denied may be appealed pursuant to the Procedures set forth below. All appeals must be filed within one hundred eighty (180) days of the date that the Claim was totally or partially denied. Failure to file an appeal of a Claim will result in the initial Claim decision becoming final and binding on all parties. Failure to file an appeal within the foregoing time limit will be deemed to void any right the claimant may have to seek judicial review of the original Claim denial.

APPEAL REVIEW TIME LIMITATIONS

The Plan Administrator shall review the initial determination and make a decision on any appeal of a Claim within the following deadlines:

- Urgent Care Claims within seventy-two (72) hours from the time the appeal was communicated.
- Pre-Service Health Care Claims within thirty (30) days from the date the plan administrator was notified of the appeal.
- Post-Service Health Care Claims within sixty (60) days from the date the plan administrator was notified of the appeal.

YOUR RIGHTS DURING APPEAL

Any individual making an appeal will have the opportunity to submit written comments, documents or other information in support of his appeal. Additionally, any individual filing an appeal will have all access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit termination will take into account all new information whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.
In the case of an appeal of a Claim denied or partially denied based on medical judgment, the plan administrator will consult with the health professional with the appropriate training and expertise. The health care professional who is consulted on appeal will not be the same individual who may have been consulted during the initial determination or subordinate of that individual. If the advise of a medical or vocation expert was obtained by the Plan in connection with the denial of your Claim, the names of each such expert shall be provided upon request. This administrative appeal process must be completed before any legal action regarding your claim can be taken. Additionally, if any such judicial proceedings are undertaken, the evidence presented shall be strictly limited to the evidence presented to the Plan Administrator pursuant to this Claim Appeal Procedures.

ADDITIONAL RIGHT AND LIMITATIONS

PLAN ADMINISTRATOR’S RIGHT TO CONSTRUE AND INTERPRET PLAN

Making any Claim determinations or signing an appeal under these Procedures, the Plan documents confers upon the plan administrator the discretion to construe and interpret the terms of the Plan and determine eligibility for benefits.

TIME LIMITATION FOR FILING INDIVIDUAL ACTION

Subject to other limitations contained in these Claim Filing and Appeal Procedures, in no event may any individual file a lawsuit seeking payment of wholly or partially denied Claims more than one year after the Claim is initially denied, or, if later, more than six months after the date the Appeal decision of the Plan Administrator is rendered.

EXTERNAL REVIEW PROCESS

A. Scope

1. The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

2. The Federal external review process applies only to:

   a. An Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan’s or issuer’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and

   b. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

B. Standard external review

Standard external review that is not considered expedited (as described in paragraph B of this section).
1. **Request for external review.** The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. **Preliminary review.** Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

   a. The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided.

   b. The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant’s failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

   c. The claimant has exhausted the Plan’s internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and

   d. The claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3282)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. **Referral to Independent Review Organization.** The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. **Reversal of Plan’s decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.
C. Expedited external review

1. **Request for expedited external review.** The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:

   a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant’s ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

   b. A final internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant’s ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.

3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for standard review. The Plan will provide or transit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process.

4. **Notice of final external review decision.** The Plan’s (or Claim Processor’s) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.
SECTION 18. GENERAL PROVISIONS

EFFECTIVE DATE

The Effective Date of the Restated Plan is September 1, 2011 as of 12:01 a.m. Standard Time at Fort Wayne, IN. Eligibility for, and the amount of benefits, if any, payable with respect to Employees of the Employer or their Dependents prior to the Effective date shall be determined in accordance with any applicable group benefit plan maintained by the Employer at that time. As of the Effective Date, eligibility for and the amount of benefits, if any, payable with respect to an Employee of the Employer or their Dependents shall be determined pursuant to the terms and conditions of this Plan Document.

PURPOSE

East Allen County Schools, hereinafter referred to as the “Employer”, has established and maintains the self-funded employee benefit plan contained herein to provide for the payment or reimbursement of specified medical, dental, prescription drug and short term disability expenses incurred by its Eligible Employees and their Covered Dependents. The name of the Plan is the EAST ALLEN COUNTY SCHOOLS HEALTH AND WELFARE PLAN. The purpose of this Plan Document is to set forth the provisions of the Plan which provide and/or affect such payment or reimbursement.

ADMINISTRATOR AND FIDUCIARY

The Plan Administrator is East Allen County Schools. The Plan Administrator controls and manages the operation and administration of the Plan and has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions. The Plan Administrator has the power to designate other persons to carry out any duty or power which would otherwise be a fiduciary responsibility of the Plan Administrator, and the Plan Administrator has delegated the daily administration of the plan to the Chief Financial Officer.

The named fiduciary of the Plan is East Allen County Schools, specific fiduciary responsibilities of the Company may be delegated to any proper person by the employer.

PLAN SUPERVISOR

The Plan supervisor provides administrative services for the Employer in connection with the operation of the Plan and performs such other functions, including processing and payment of claims, as may be delegated to it. The Plan Supervisor is Employee Plans, L.L.C., 1111 Chestnut Hills Parkway, (P.O. Box 2362), Fort Wayne, IN 46801, phone (260) 625-7500.

DISCLAIMER

If language in the Summary Plan Description conflicts with the wording of the Plan or insurance contracts, the language in these documents shall have control over the language in the Summary Plan Description.

AMENDMENT

The Plan may be amended, canceled or discontinued at any time by the Employer without the consent of or notice to any Covered Person. All amendments shall be approved by the Employer’s Board of Directors or other Governing body. Additionally, all amendments shall be communicated to the Participants as soon as practical after adoption of the amendment. Any amendment which decreases coverage shall be communicated to the Participants a reasonable period of time before the amendment becomes effective.
EXCLUSION OF TEMPORARY, LEASED, OR MISCLASSIFIED EMPLOYEES

The following classes of individuals are ineligible to participate in this Plan, regardless of any other Plan terms to the contrary, and regardless of whether the individual is a common law employee of the Employer:

1. any worker who has signed an employment agreement, independent contractor agreement, or other personal services contract with the Employer stating that he or she is not eligible to participate in the Plan;

2. any worker that the Employer treats as an independent contractor, during the period that the worker is so treated. A worker is treated as an independent contractor if payment for his or her services is memorialized on a form 1099, and not on a form W-2;

3. any leased employee within the meaning of §414(n) of the Internal Revenue Code, or any person that would be a leased employee but for the fact that he or she is the common law employee of the Employer;

4. any individual hired by the Employer who is an intern, contingent, supplemental, per diem, or temporary employee.

The purpose of this provision is to exclude from participation in the plan all persons who may actually be common law employees of the Employer, but who are not paid as though they were employees, regardless of the reason they are excluded from the payroll, and regardless of whether that exclusion is correct.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

Funding is derived solely from the funds of the Employer. The level of any Employee contributions will be set by the Plan Administrator. Employee contributions will be used to fund the costs of the Plan as soon as practical after they have been received from the Covered Person or withheld from the Employee’s pay through payroll deduction. Benefits are paid directly from the Plan by the Plan Supervisor. The employer may purchase “excess loss” or “reinsurance” from a licensed insurance company to reimburse the Plan for certain catastrophic claims which exceed the thresholds set forth in the reinsurance contract, but no participant has any right to receive a reimbursement directly from the reinsurance carriers.

CONFORMITY WITH LAW

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

STATEMENTS

In the absence of fraud, all statements made by a Covered Person will be deemed representations not warranties. No such representations will be used to void coverage or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Person.

MISCELLANEOUS

Section titles are for convenience of reference only and are not to be considered in interpreting the Plan.

No failure to enforce any provision of the Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.
PAYMENT OF BENEFITS

The Employer will pay, or cause to be paid, all benefits payable under the terms and conditions of the Plan. The Employer assures the Covered Persons that all benefits described in this Plan Document will be paid promptly upon receipt of proof that covered Expenses have been incurred.

EXAMINATION

The Employer shall have the right and opportunity to have a Covered Person examined by a Physician as often as is reasonably necessary while a claim is pending for an Injury or Illness. The Employer shall also have the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

RIGHTS OF RECOVERY

Whenever payments have been made by the Plan with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intention of the Plan, the Plan Administrator shall have the right, exercisable alone and in its sole discretion, to recover such excess payments.

FUTURE OF THE PLAN

The Plan Administrator, as listed in the section on GENERAL PROVISIONS, intends to continue the Plan, but reserves the right to terminate it or amend it in any way. If the Plan should be discontinued, all eligible claims outstanding at that time will be paid in full or paid on a prorated basis.

CONTRIBUTIONS

The cost of The Plan is paid with contributions by East Allen County Schools and by employees. The amount of such contribution is determined by the employer.

PLAN DOCUMENTS

The Plan Document and the reinsurance contract contain all the provisions of the plan and govern its legal operations.

The Plan Document, as well as the Annual Report of the Plan filed with the U.S. Department of Labor, is available for review at Company offices during normal working hours.

Copies of these documents will be furnished to Covered Persons at a reasonable charge within thirty (30) days of a written request.

PLAN NAME AND IDENTIFICATION NUMBER

EAST ALLEN COUNTY SCHOOLS

Employer Identification Number: 35-1097344.

The Plan Number assigned by the company: 501.

PLAN SPONSOR AND ADMINISTRATOR

EAST ALLEN COUNTY SCHOOLS

1240 St. Rd. 930 East

New Haven, IN 46774
ADMINISTRATOR OF PLAN

EAST ALLEN COUNTY SCHOOLS is liable for all benefits under the Plan. Employee Plans, LLC administers payment of claims.

TYPE OF ADMINISTRATOR

Third party contract with Employee Plans, LLC, service of legal process may be made upon the Plan Administrator:

______ EAST ALLEN COUNTY SCHOOLS ________

______ 1240 St. Rd. 930 East ________________

______ New Haven, IN  46774 ________________

PLAN YEAR

The financial records of the Plan are kept on a plan year basis ending on each 8-31.