City of Mattoon
Group Health Benefits Plan

January 1, 2004

ERISA Summary Plan Description. This document constitutes the Summary Plan Description required by the Employee Retirement Income Security Act of 1974 ("ERISA") § 102.

ERISA Plan Document. Portions of this document also constitute the written plan document for the City of Mattoon Group Health Benefits Plan required by ERISA § 402.

SUMMARY PLAN DESCRIPTION OF THE GROUP HEALTH CARE PLAN FOR THE EMPLOYEES OF THE CITY OF MATTOON

EFFECTIVE: JANUARY 1, 2004

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THE VALUE OF YOUR HEALTH BENEFIT PLAN

This Health Benefit Plan provides you and your family with important protection against financial hardship that often accompanies illness or injury. It has been carefully designed to provide excellent medical benefits and offers financial incentives if you seek the most efficient quality healthcare services available. The City of Mattoon provides the Health Benefit Plan for you and your family.

The PPO Option Is An Important Cost Containment Feature Provided By This Benefit Plan. When You And Your Dependents Use PPO Providers, You Not Only Reduce Your Out-Of-Pocket Expenses, But You Also Conserve Valuable Plan Resources. Conservation Of Plan Resources Is Essential To Continuing The High Level Of Benefits Provided By This Plan.

This Booklet describes your health care coverage, explaining:

- How you become eligible to participate,
- What benefits are available to you and your family, and
- How the Plan is administered.

This Booklet is designed to provide a general, easy-to-read explanation of your Health Benefit Plan. The complete provisions of the Plan are contained in the official Plan Document, which governs in the case of any differences between it and this Booklet. You may obtain a copy of the Plan Document from the City.

Wherever used in this Booklet, masculine pronouns are intended to include the feminine, and singular pronouns are intended to include the plural, wherever the context requires.

We hope you'll take the time to review your benefit coverage from the **City of Mattoon** and share with your family ways to do your part to make the health care system work cost effectively and efficiently for you.

Benefits described in this Booklet may change from time to time. You should ensure that you have the most current Booklet by contacting the City Clerk's Office.

Schedule of Benefits (Face Sheet)

This is a summary of your benefits. See your Summary Plan Description for more detailed information.

Plan Name: **City of Mattoon Group Health Benefits Plan**
Effective Date: **January 1, 2004**
Medical Package: **City of Mattoon PPO/ASO**
Rx Package: **See Applicable Rider**

BASICS	Maximums, Deductibles, and Limitations	
Annual Medical Deductible	In-Network	Out-of-Network
Individual	$300	$500
Family	$600	$1,000
	Deductibles must be met first. The family maximum includes covered expenses which are used to satisfy deductibles for all family members combined. Well baby and well child care, routine immunizations, routine examinations (including gynecological examinations), accident benefit and second surgical opinions are not included on your deductible. Any covered medical expenses incurred and applied toward the individual and family deductible amount during the last three (3) months of the year (Oct, Nov, Dec) are applied to the individual and family deductible amount for both present and the following calendar years. Out-of-pocket reimbursement of 100% does not carry over.	
Out-of-Pocket Maximum	In-Network	Out-of-Network
Individual	$1,000	$2,000
Family	$2,000	$4,000
	The family out-of-pocket maximum includes out-of-pocket maximums for all family members combined. In- and Out-of-Network expenses will be applied equally toward the satisfaction of both the In- and Out-of-Network out-of-pocket maximums. Does not include contract year deductibles, prescription drug co-payments, charges in excess of benefit maximums or U&C fees, and non-compliance penalties.	
Lifetime Maximum	$2,000,000	
Prior Authorization Requirements	Certain services (including all surgeries and hospital admissions) require prior authorization. Failure to prior authorize will result i a fifty percent (50%) reduction in benefits.	
Maximum Allowable Charge	Except for emergency services, charges by out-of-network providers in excess of maximum allowable charge will not be covered.	
Benefit Maximums	Any maximums which are stated in dollar amounts, number of days or number of treatments and which limit either the maximum benefits payable or the maximum allowable covered expenses are the combined maximums under both the in- and out-of-network level of benefits.	
Annual Pharmacy Deductible per Individual	N/A	
Annual Pharmacy Maximum	N/A	

IN THE HOSPITAL	Description	You Pay In-Network	You Pay Out-of-Network
Hospital Care	Hospital services are covered when prior authorized. The Plan should be notified of emergency admissions within 48 hours.	10% coinsurance per admission	30% coinsurance per admission
Number of Days of Inpatient Care	Unlimited number of medical/surgical stays, subject to medical necessity.	See Hospital Care	See Hospital Care
Room and Board	Coverage is provided for semi-private room and board or specialty unit, when medically necessary.	See Hospital Care	See Hospital Care
Medications	Coverage is included under Hospital Care. Take-home drugs dispensed to you prior to your release are not covered. You may have benefits as outlined in a prescription drug rider, if applicable.	See Hospital Care	See Hospital Care
Other Miscellaneous Charges	Coverage is included under Hospital Care. Personal comfort or convenience items are not covered.	See Hospital Care	See Hospital Care
In-Patient Physician Services	Includes radiologist, pathologist, anesthesiologist, emergency room physician, among others. Captive services will be paid at in-network benefit level.	20%	30%
Surgical Physician Services		10%	30%
Second Surgical Opinion	Requires notification to Plan.	0%	0%
Procedures, Diagnostics, and Therapeutics	Includes x-ray examinations, laboratory tests, therapeutics and pathology services.	20%	

IN THE DOCTOR'S OFFICE	Description	You Pay In-Network	You Pay Out-of-Network
Primary Care Physician (PCP)	Evaluation and Management Services; includes nurse practitioners and physician assistants.	10%	30%
Specialist Other Than Listed in Medical Services	Evaluation and Management Services; includes nurse practitioners and physician assistants.	10%	30%
Procedures, Diagnostics and Therapeutics	Includes x-ray examinations, laboratory tests, therapeutic injections, therapeutics and pathology services.	20%	
Well Baby and Well Child Care	Covered when administered by in-network providers.	0%	Not Covered
Adult/Child Immunizations	Covered when administered by in-network providers.	0%	Not Covered
Routine Examinations	No coverage out-of-network except for mammograms/pap smears where you pay a 20% coinsurance.	0%	Not Covered
Allergy Treatment and Testing	Covered. See Summary Plan Description for further information.	See In The Doctor's Office: Procedures, Diagnostics, and Therapeutic Services.	
Wellness Care	According to published preventive care guidelines.	See applicable office visit, hospital, and outpatient services sections for copayment or coinsurance.	

MEDICAL SERVICES	Description		You Pay In-Network	You Pay Out-of-Network
Outpatient Surgery	Except for minor surgeries or diagnostic procedures performed in doctor's office, requires prior authorization		10%	30%
Outpatient Observation Stays	Observation services are covered up to 24 hours when prior authorized.		10%	30%
Outpatient Diagnostics and Therapeutics			20%	
Maternity Care Hospital Care	Coverage for 48 hours of inpatient care following a vaginal delivery or 96 hours of inpatient care following a delivery by cesarean section. Inpatient care beyond these timeframes requires prior authorization.		10%	30%
Physician Care	Routine prenatal, delivery, and postnatal care.		10%	30%
	Care provided by other physicians and specialists may result in assessment of additional copayments/coinsurance.		See applicable office visit, hospital, and outpatient services sections for copayment or coinsurance.	
Infertility Services	Infertility means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.		Not Covered.	
Mental Health		Covered per contract year:		
Inpatient	When prior authorized.	60 Days	20%	
Outpatient	Benefit maximum combined w/ substance abuse care	30 Visits	20%	
Substance Abuse		Covered per contract year:		
Inpatient	When prior authorized.	30 Days	20%	
Outpatient	Benefit maximum combined w/ mental health care	30 Visits	20%	
Rehabilitation Services Inpatient and Outpatient	Includes physical, occupational, speech and cardiac rehabilitation therapies. Benefit maximum of 60 days per illness or injury.		10%	30%
Anesthesiologist Services	Professional fees. Captive services paid at in-network benefit level.		20%	30%
Radiologist and Radiology Services	Professional and technical fees. Captive services paid at in-network benefit level.		20%	30%
Pathologist/Laboratory Services	Professional and technical fees. Captive services paid at in-network benefit level.		20%	30%

EMERGENCY SERVICES	Description	You Pay	
Emergency Room Medical Services	$50 co-payment per ER visit up to maximum of $300. Remaining eligible expenses payable at applicable coinsurance rates.	10%	30%
Emergency Room Accident Services		10%	10%

Emergency Room Physician Services	Professional fees.	20%
Emergency Transportation by Ambulance	Covered when medically necessary for land or air transport within continental USA/Canada.	20%
Emergency Post-Stabilization Services	Covered when medically necessary.	See Hospital Care for applicable coinsurance or co-payment.

OTHER MEDICAL SERVICES	Description	You Pay In-Network	You Pay Out-of-Network
Durable Medical Equipment	Covereage for medically necessary, standard model equipment.	20%	
Prosthetic Devices	Coverage for medically necessary, standard model prostheses, prosthetic appliances and implants.	20%	
Hospice	Covered (up to six months).	10%	30%
Home Health Care	100 visit limit per contract year.	10%	30%
Private Duty Nursing	Limited to $1,000 per month	10%	30%
Vision Care	Not covered. Coverage for vision screening and refractive services may be covered by a separate vision plan, if applicable.	Not applicable	Not applicable
Dental Services	Not covered. Coverage for dental services may be covered by a separate dental plan, if applicable.	Not applicable	Not applicable
Skilled Nursing Facilities	Short-term, non-custodial care in a skilled nursing facility is covered when medically necessary for convalescence from an illness or injury.	10%	30%
Chiropractic Services	Limited to 20 visits per contract year not to exceed $500.	20%	
Organ Transplants	Covered when medically necessary and when prior authorized, performed at an approved Coventry Transplant Network participating facility, and not experimental or investigational.	10%	Not covered
TMJ Care	Includes diagnosis & treatment w/ a lifetime maximum benefit of $1,000.	10%	30%
Morbid Obesity	Charges for Medically Necessary treatment of obesity are limited to a lifetime maximum benefit of $15,000. Prior authorization required.	10%	30%
Prescription Drugs	There is a 50% coinsurance per prescription for a brand name prescription when a generic is available	Generic: $15 co-payment	
		Brand name: $15 co-payment	
Mail Order Maintenance Drugs and Medications	There is a 50% coinsurance per each order of a 3-month supply of a brand name prescription drug when a generic is available.	Generic: $15 co-payment	
		Brand name: $15 co-payment	

PREFERRED PROVIDER ORGANIZATION (PPO)

Certain hospitals and physicians may participate in a PPO with this Health Benefit Plan. PPO providers have entered into an agreement to provide services at a discounted fee arrangement. The PPO offers access to quality health care services by conveniently located providers at substantial savings to Covered Persons. A list of the hospitals and physicians participating in the PPO is provided to the City for distribution to their employees. A copy may also be obtained free of charge upon request by contacting the Claims Administrator's Customer Service Department. This list of PPO providers will be updated periodically.

A Covered Person has freedom of choice in selecting a health care provider. Covered Persons may receive Covered Services from Participating PPO Providers included in the PPO network of Providers. In addition, Covered Persons may receive certain Covered Services from Non-Participating Providers. However, there are benefit differences depending on whether services are rendered by a PPO provider or by a Non-PPO provider. These differences are shown on the Schedule of Benefits. Those Covered Services for which there is not Out-of-Network Coverage are identified in this Plan Document and/or in the Schedule of Benefits.

Except for Emergency Services, coverage for Covered Services provided by Non-Participating Providers is limited to the Out-of-Network Rate less applicable Co-payments, Coinsurance and Deductibles. The Out-of-Network Rate is equivalent to the current Medicare fee schedule or diagnosis group rate, as applicable, for the services and supplies rendered, taking into account the appropriate Medicare geo-graphic adjustments. If there is no corresponding Medicare rate for the particular service, the Plan shall pay the amount that the Plan would have paid if the Non-Participating Provider furnishing the services were a Provider contracting with the Claims Administrator.

If the amount a Covered Person is charged for a service is equal or less than the Out-of Network Rate, the charges should be completely covered by the Out-of-Network Benefit, except for any Co-payment, Deductible and Coinsurance payments. However, if the amount a Participant is charged is in excess of the Out-of-Network Rate for a particular service, the Covered Person must pay the excess. For example, assume the Coinsurance is 20%, the doctor's bill is $150 and the Out-of-Network Rate is $100. In this example, Plan would pay $80, the Covered Person would pay Coinsurance of $20 plus the $50 in actual charges that exceed the Out-of-Network Rate. Payments for charges in excess of reasonable and customary fees of the Out-of-Network Rate do not count towards the annual out-of-pocket maximum.

If there are no hospitals and physicians participating in a PPO in an area where a Covered Person is located, the Non-PPO benefits will apply as shown on the Schedule of Benefits. However, if a Covered Person requires treatment for an accident or medical emergency as defined, and cannot reasonably reach a PPO provider, benefits for the initial treatment by a Non-PPO provider will be paid at the PPO benefit level. Additionally, if a Covered Person is admitted to a Non-PPO hospital as a result of a medical emergency, benefits for

stabilization and initiation of treatment will be paid at the PPO benefit level until it is medically appropriate for the Covered Person to be transferred to a PPO hospital. The determination of when the transfer is medically appropriate will be made by the Covered Person's physician and the Utilization Review Service.

If the Covered Person chooses to remain in a Non-PPO hospital after it has been determined that he could have been transferred to a PPO hospital, covered expenses will be paid at the Non-PPO benefit level. If charges are incurred for services performed by a Non-PPO provider which the patient did not have the option to choose, but performed in a PPO Hospital, such charges will be paid at the PPO benefit level. This provision applies to, but is not limited to, services provided by an emergency room physician, a radiologist, a pathologist or anesthesiologist.

If charges are incurred for services performed by a Non-PPO provider or received in a Non-PPO facility which were ordered by a PPO provider, such charges will be paid in accordance with the PPO benefit level.

If a referral is made to a Non-PPO provider by a PPO provider for Medically Necessary services, the services performed by the Non-PPO provider will be covered at the PPO benefit level.

If, while being treated by a PPO physician or at a PPO hospital, services are performed by a Non-PPO provider (e.g., emergency room physician, radiologist, anesthesiologist, pathologist) which is requested or required by that PPO physician or PPO hospital, the charges will be covered at the PPO benefit level.

Should you choose a provider that is participating in the PPO network, that provider will discount fees charged for the services rendered. Such discounts will be identified on your Explanation of Benefits (EOB). The discounts offered by the participating providers will be credited to your billing record. Should you ever be billed by a PPO provider for the discounts, notify the Claims Administrator, who will then contact the provider for the appropriate adjustment.

IMPORTANT--The requirements of the Utilization Review program must be followed in order to receive full benefits under the Plan, whether a PPO or Non-PPO provider is used. In addition, when using a PPO provider, benefits must be assigned to that provider.

IMPORTANT NOTICES

Important Notice for Mastectomy Patients

If a Covered Person elects breast reconstruction in connection with a mastectomy, the Covered Person is entitled to coverage under this Plan for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

Such services will be performed in a manner determined in consultation with the attending physician and the patient. See the Medical Expense Benefits Section for further details regarding this coverage.

Special Rights on Childbirth

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother (if a covered person) or newborn child (if a covered person) 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 may not, under federal law, require that a provider obtain authorization from the Plan or the Claims Administrator for prescribing a length of stay not in excess of 48 hours (or 96 hours).

UTILIZATION REVIEW PROGRAM

The benefits provided by this Plan are limited to charges for non-emergency, elective surgery or hospital confinement *only if* the surgery or hospital confinement, or the length of hospital confinement, is necessary for the care and treatment of an illness or injury. This Plan has a program of Utilization Review so that you may understand the medical necessity of a proposed hospital confinement or surgery recommended by your Physician. The Utilization Review Service is staffed by medical professionals who consult with you and your Physician to determine the type of care required, the appropriate setting for such care, and quality, yet cost effective, care for your condition.

PLEASE CONTACT THE CLAIM'S ADMINISTRATOR'S CUSTOMER SERVICE DEPARTMENT AT 217-366-1226 or 866-557-8751 IN ORDER TO COMMENCE THE UTILIZATION REVIEW PROCESS. THESE PHONE NUMBERS ARE ALSO DISPLAYED ON THE BACK OF YOUR PERSONALCARE IDENTIFICATION CARD.

ALL BENEFITS PROVIDED BY THIS PLAN FOR CHARGES FOR HOSPITAL CONFINEMENTS OR ELECTIVE SURGERY ARE SUBJECT TO THE FOLLOWING REQUIREMENTS:

PRE-ADMISSION REVIEW

For Non-Emergency Hospital Admissions:
A pre-admission authorization is required at least twenty-four (24) hours prior to your admission to a hospital as a bed patient. You, a member of you family, your physician or the hospital must call the Utilization Review Service whenever a hospital admission is recommended. The Utilization Review Service will evaluate your planned treatment based upon the diagnosis provided by your physician and established standards for medical care. After reviewing the pre-admission authorization, the Utilization Review Service will provide written notice to you, your authorized representative, your physician, and the hospital of the benefit determination under the time frames set forth below. The Utilization Review Service's authorization does not verify eligibility or benefits. Questions regarding eligibility or benefits must be directed to the Claims Administrator's Customer Service Department.

For Emergency Hospital Admissions:
"Emergency Hospital Admission" means an admission for hospital confinement, which if delayed, would result in your disability or death. In case of an emergency hospital admission, you, your physician, the hospital or a member of your immediate family must inform the Utilization Review Service of the admission, by telephone, within forty-eight (48) hours after such admission.

For Maternity Hospital Admissions:
Maternity admissions are not considered emergencies. A pre-admission authorization is required at least two (2) months prior to the estimated date of delivery. You, a member of your family or your Physician must call the Utilization Review Service to obtain this pre-admission authorization.

The Utilization Review Service must be informed of:

- The name and birth date of the patient
- The name and social security number of the employee
- The date of hospital admission or surgery
- The name of the employer
- The admitting diagnosis
- The name of the hospital
- The name and telephone number of the attending physician

CONTINUED STAY REVIEW
Before your scheduled discharge, the Utilization Review Service will call the hospital and your physician to confirm your discharge. If additional days of confinement are required because of complications or other medical reasons, the Utilization Review Service will again evaluate the treatment and diagnosis in consultation with your physician. This process will continue until you are discharged from the hospital.

WHAT OCCURS IF UTILIZATION REVIEW IS NOT USED:
If hospital charges are incurred by a Covered Person for a period of hospital confinement, and such confinement has NOT been authorized by the Utilization Review Service as set out above under the Pre-Admission Review provisions, the hospitals charges for **covered expenses will be reduced by 50%, subject to any applicable deductible or co-payments** regardless of whether the hospitalization was Medically Necessary. In addition, if hospital charges are incurred by a Covered Person for a period of ongoing hospital confinement which has NOT been authorized under the Continued Stay Review provisions set forth above, the eligible hospital charges for such confinement will be limited to the charges incurred during the period of hospital confinement initially authorized, and the charges for the remaining days of your stay will become your financial responsibility. **THE NON-COMPLIANCE PENALTIES WILL NOT ACCUMULATE TOWARD THE REQUIRED DEDUCTIBLES OR TO THE OUT-OF-POCKET MAXIMUMS.**

PRE-SURGICAL REVIEW

Non-Emergency Surgery:
If your physician recommends non-emergency surgery, meaning surgery that can be postponed without causing undue risk to the patient, you, a member of your family or your physician must contact the Utilization Review Service at least twenty-four (24) hours prior to the proposed surgery for preauthorization. ***Pre-Surgical Review is not required for minor surgical and diagnostic procedures performed in a physician's office.***

SECOND SURGICAL OPINION

The Utilization Review Service will evaluate the information provided and advise you and/or your physician if a second surgical opinion is required. The Plan will pay the physician's reasonable and customary charge for a required second surgical opinion. If the second surgical opinion does not confirm the advisability of the proposed surgery, a third opinion may be arranged and will be paid for in the same manner as the second. If you choose to proceed with an elective surgical procedure without contacting the Utilization Review Service for prior authorization or if you choose to proceed with elective surgery when the necessity has not been confirmed by a second (or third) opinion, **all covered expenses related to the surgery will be reduced by 50%,** subject to any applicable deductibles or co-payments. **THE NON-COMPLIANCE PENALTY WILL NOT ACCUMULATE TOWARD THE REQUIRED DEDUCTIBLES OR TO THE OUT-OF-POCKET MAXIMUMS.**

RETROSPECTIVE REVIEW

The Utilization Review Service will review and evaluate the medical records and other pertinent data of an individual whose hospital stay, or a portion of his stay, was not authorized under the Pre-Admission and/or Continued Stay Review provisions of the Plan.

Requests for such review will be made telephonically by the Utilization Review Service to the attending physician or hospital and will define the medical basis for the review.

Benefits will be limited to only those expenses incurred during the period of hospitalization which would have been authorized. Benefits are not payable for expenses related to any period of hospital confinement which is deemed not medically necessary.

NOTICE OF BENEFIT DETERMINATION

Urgent Care Claims

When the Plan receives a request for Urgent Care that is not an Emergency Service and that satisfies the requirements of the Urgent Care Claims definition, the Plan will notify the Covered Person and/or Authorized Representative of the decision by telephone within one (1) business day and in writing no later than forty-eight (48) hours after the request is received. This notification will be made whether or not there is an Adverse Benefit Determination. If there is insufficient information for the Plan to make a decision, the Plan will notify the Covered Person and/or Authorized Representative no later than twenty-four (24) hours after receiving the request for Urgent Care. The notice will detail the information that is needed to make the decision. The Covered Person and/or Authorized Representative has forty-eight (48) hours to provide the requested information. The Plan will make the decision within forty-eight (48) hours after the earlier of:

- the receipt of the additional information; or
- the end of the end of the forty-eight (48) hour period in which the Covered Person or Authorized Representative has to provide the information.

Pre-Service Claims

When the Plan receives a request for Prior Authorization of a hospital admission or other service that is not an Urgent Care Claim, the Plan will notify the Covered Person and/or Authorized Representative of the authorization decision, in the case of an Adverse Benefit Determination, no later than two (2) business days after the request and all necessary information are received by the Plan; and, in the case of all other requests, no later than fifteen (15) days after the request and all necessary information are received by the Plan. This notification will be made whether or not there is an Adverse Benefit Determination. If the Plan does not have all the necessary information to make the authorization decision, the Plan will notify the Covered Person and/or Authorized Representative and explain in detail what information is required. The Plan must receive the information requested within forty-five (45) days from the Covered Person's and/or Authorized Representative's receipt of the notice to provide the additional information. If the Prior Authorization procedures are not followed, the Plan will notify the Covered Person and/or Authorized Representative of the failure to follow the procedures within five (5) days of the request. The notice will include the proper procedures for requesting Prior Authorization.

Post-Service Claims
The Plan will send a notice of an Adverse Benefit Determination (in an Explanation of Benefits) to the Covered Person or Authorized Representative within thirty (30) days after the Claims Administrator receives the claim for payment. If the Claims Administrator does not have the necessary information to make a payment determination, the Claims Administrator will notify the Covered Person or the Authorized Representative of the need for an extension before the end of the initial thirty (30) days. The extension notice will explain in detail what information is required. The Covered Person or Authorized Representative has forty-five (45) days from the receipt of the notice to provide the requested information. The Plan has fifteen (15) days from receipt of the clarifying information or the end of the forty-five (45) day period, whichever is earlier, to make a determination.

Ongoing Treatment
The Plan does not reduce or terminate coverage for care that is Pre-Authorized, as long as the information the Plan was provided to obtain the Prior Authorization is accurate and the Covered Person remains enrolled in the Plan. If the Plan receives a request to extend care beyond what the Plan has Pre-Authorized, the Plan will follow the Urgent Care Claims process above.

Appeal Rights
If an Urgent Care Claim, a Pre-service Claim or a Post-service Claim results in an Adverse Benefit Determination, the Covered Person or Authorized Representative may appeal the decision as set forth in other sections of this Plan Summary.

CASE MANAGEMENT SERVICES

Case Management is an added service provided by this Health Plan which is used to assist seriously ill or injured Covered Persons requiring long-term care. Case Management nurses provide intensive planning and management for these special situations by recommending alternate treatment plans, arranging home health care services and equipment rental and coordinating the services of the many providers that may be involved in these designated situations. Examples of illnesses or injuries which may benefit from Case Management services are stroke, premature birth, some forms of cancer, severe burns and head injury. The Covered Person must cooperate with the Case Manager and provide all relevant medical information regarding his condition; however, the choice of the course of treatment ultimately belongs to the patient. *Certain circumstances may cause the Plan Administrator to allow charges that would not otherwise be covered if the proposed alternative is shown to be cost effective.* Prior to any final determination, the severity of the condition and the prognosis are taken into consideration. The Plan Administrator shall have the right to waive the normal provisions of the Plan when it is reasonable to expect a cost effective result without sacrifice to the quality of patient care.

HOW TO FILE A CLAIM

GENERAL INFORMATION

Under most circumstances, your Health Care Provider will submit a claim for payment directly to the Claims Administrator, and you will not need to worry about filing a claim.

However, occasionally, you may pay for a provider service yourself up front or visit a provider who is unfamiliar with how to submit a claim to the Claims Administrator. In these circumstances, you will be responsible for submitting a claim and ensuring that the claim gets paid.

To Receive Prompt And Full Payment For The Medical Expenses Reimbursable Under This Plan, A Health Claim Form Must Be Submitted For Each Covered Person Once Each Calendar Year And An Additional Claim Form Must Be Submitted For The First Claim Related To An Accident.

Read the claim form carefully. Answer all of the questions on the form and include all required information. The claim form has an "Authorization To Pay Benefits To Physician". This should be signed if you have NOT PAID the bill and you want payment made to the provider of service. You should ALWAYS sign the "Authorization To Release Information".

Health claim forms are available from the City Clerk's Office.

HOW TO FILE A MEDICAL CLAIM

Obtain a medical claim form from the City Clerk's Office.

One claim form is to be completed for each family member, each calendar year. Another claim form need not be completed unless the claim which is being submitted is the first claim related to an accident or unless there has been a change in your spouse's employer or spouse's insurance coverage or a change in a full-time student's school status. Every medical claim must also include a physician's statement specifying the nature of the illness or injury for which reimbursement is requested. The Claims Administrator will typically accept a diagnostic statement on any form which your doctor prefers to use. ***WITHOUT A DIAGNOSIS, YOUR CLAIM CANNOT BE PROCESSED.*** All bills, except those for drugs, must indicate the patient's full name, the nature of the illness or injury, the date(s) of service, the type(s) of service and the charge for each service and the name, address and tax identification number of the provider.

HOW TO FILE A PRESCRIPTION DRUG CLAIM

For reimbursement of prescription drug expenses under the Medical Expense Benefit Plan, submit your bills indicating the patient's full name, the name of the prescribing physician, the prescription number and the name of the medication, the charge for each prescription and the date of each purchase. When prescription drugs are purchased through the Prescription Drug Plan, a claim submission is not necessary. Your only responsibility is to pay the applicable co-payment at the time you purchase the prescription.

Should there be a primary insurance carrier for a member of your family, it is important to submit a copy of the itemized claim with a copy of the primary carrier's Explanation of Benefits statement indicating payment or denial of the charges.

HOW TO SUBMIT A MEDICARE CLAIM

A Medicare claim is submitted as previously explained; however, when you submit the claim, be sure you also submit the Explanation of Benefits (EOB) which you receive from Medicare. The Claims Administrator may be unable to accurately determine benefits payable under the Plan without the Medicare EOB.

WHERE TO SUBMIT A CLAIM

Completed claim forms and itemized bills should be submitted to the address indicated on your PersonalCare Identification Card. **ALWAYS RETAIN A COPY FOR YOUR RECORDS.**

SUBMISSION OF CLAIM

All charges should be submitted within three (3) months after the date incurred, except that failure to submit within the stated time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to submit such claim in a timely manner and that the claim was submitted as soon as was reasonably possible.

RIGHT TO RECOVER

If the Plan pays for covered expenses in excess of the amount that should have been paid to fulfill its obligations under the terms of the Plan, the Plan Administrator and/or Claims Administrator has the right to recover the amount of payment in excess of the amount that should have been paid. If a Covered Person is paid more than allowed by the Plan, the Covered Person must refund that overpayment. A request for refund will be made in writing by this Plan. If an overpayment is made by the Plan on behalf of the Covered Person to a hospital, physician or other provider, this Plan may request a refund of the overpayment from either the Covered Person or the provider, or, if applicable, any insurance company or other organization. If the refund is not received from the Covered Person, provider, insurance company or other organization, the overpayment shall be

deducted from any future Plan benefits available to the Covered Person or collected through legal process.

DENIAL OF CLAIM

In the event a claim is denied in whole or in part, written notice shall set forth the specific reasons for the denial. If the claimant does not wish to abide by the decision of the Plan Administrator, within sixty (60) days of receipt of the decision of the Plan Administrator, the claimant shall resubmit the claim. Within sixty (60) days of the receipt of the resubmitted claim, the Plan Administrator shall render a written decision on such claim either approving or disapproving the claim in whole or in part. Notice of such decision shall be given to the claimant by mailing a copy to him at his last known address.

PLAN PARTICIPATION

You must enroll for coverage under this Plan by obtaining an enrollment form from the City Clerk's Office. Complete the form in full, sign and return it promptly to the City Clerk's Office.

ELIGIBLE EMPLOYEES

All full-time employees and part-time employees who work at least twenty-four (24) hours per week.

Retirees - as defined. The Retired Employee may elect to keep any family members covered by the Plan only if those family members were covered under the Plan immediately preceding the date of retirement.

A surviving spouse and the spouse's eligible dependents of a retired employee, who in that capacity, is entitled to receive a surviving spouse's monthly pension, until the death or remarriage of that spouse.

All full-time employees when on active duty with any component of the United States military or a State militia as required by the Laws of the State of Illinois and the United States.
Note: The Plan will provide coverage for the Covered Person's eligible dependents when the Covered Person has been called to active military duty with the armed forces of the USA. The Plan will be secondary to TRICARE, unless the ***existing*** providers used by the eligible dependents are excluded under the TRICARE plan. In this case, this Plan will be primary.

Elected Officials - as defined.

WHEN EMPLOYEES BECOME ELIGIBLE

WAITING PERIOD
A "***Waiting Period"*** is the time between the first day of employment and the first day of coverage under the Plan.

ENROLLMENT DATE
The ***"Enrollment Date"*** is the first day of coverage or, if there is a waiting period, the first day of the waiting period. *You are eligible for* ***Medical Coverage*** *after thirty (30) days of continuous full-time employment.* If you return from a leave of absence which qualifies under the Family and Medical Leave Act (FMLA), and you chose not to retain health coverage under this Plan during such leave, your coverage will be reinstated upon return from such leave, without any waiting period if you previously satisfied any applicable waiting period.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

Your coverage begins on the date on which you become eligible for Plan benefits provided you have completed an enrollment form and make any required contributions. If you apply for coverage on or before your eligibility date, or within thirty-one (31) days after your original enrollment date, your coverage will begin on your original eligibility date. If you terminate your employment, for any reason, during your eligibility waiting period and are subsequently re-employed, you must complete the same eligibility waiting period as applied to a new employee. This requirement applies to both you and your eligible dependents.

LATE ENROLLMENT

"Late Enrollee" means an individual who enrolls under the Plan other than during the first thirty-one (31) day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period. Submission of Evidence of Good Health or Insurability is no longer required. If you do not apply for coverage within thirty-one (31) days of the date you become eligible, or during a Special Enrollment Period, or if you previously elected to end your coverage in the Plan, an active employee may apply for coverage at any time. The effective date of coverage will be the first of the month following the date you complete an enrollment form and make any required contributions. If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee. The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage as a Late Enrollee is not treated as a waiting period.

EMPLOYEES WHO ARE NOT ELIGIBLE

Part-time employees working less than twenty-four (24) hours per week, temporary or substitute employees. This does not apply to a regular, full-time employee if and while he is only temporarily working for the City on a part-time basis.

DISCONTINUANCE OF COVERAGE BY RETIRED EMPLOYEES

A retiree may discontinue participation in coverage at any time by submitting a signed, written request to the City Clerk. Premium deductions will be stopped as soon as possible. Coverage will end on the last day of the month in which the last premium is deducted or paid. If a retiree discontinues participation, the retiree waives all rights to future coverage and is not eligible to re-enroll.

WHEN EMPLOYEES CEASE TO BE ELIGIBLE

All Plan coverage will terminate on the earliest of the following dates:

- The date your employment terminates.
- The date you cease to be in a class of employees eligible for coverage.
- The date you cease to be an eligible employee.
- The end of the period for which you made any required contributions, if you fail to make any further required contributions.
- The date the Plan is terminated.
- If you materially violate the terms of the Plan.
- If you participate in fraudulent or criminal behavior. Examples of fraudulent or criminal behavior include, but are not limited to:
    - Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts including using an identification card to obtain goods or services which are not prescribed or ordered for you or to which you are otherwise not legally entitled.
    - Allowing any other person to use an identification card to obtain services.
    - Threatening or perpetrating violent acts against the Plan, a Provider, the Claims Administrator, or an employee of the Plan, Provider or Claims Administrator.
- If you knowingly misrepresent or give false information on any enrollment application form which is material to the Plan's acceptance of such application.
- If you are absent from work due to an approved leave of absence, other than a Family and Medical Leave Act leave, coverage terminates following the period of the approved leave.
- If you are absent from work due to a temporary layoff, coverage terminates the date of the layoff.
- If you are absent from work due to a job-related disability, eligibility for coverage will continue as if you were a retired employee.
- If you are absent from work due to a non-job related disability, eligibility for coverage terminates the date your employment ends subject to continuation rights for continued coverage after you cease to be eligible under the Plan.

This Plan is subject to compliance with the provisions of the Family and Medical Leave Act (FMLA) that became effective August 5, 1993 as it may be amended from time to time.

Refer to the section in this Booklet entitled CONTINUATION RIGHTS for information regarding continued coverage after you cease to be eligible under the Plan.

ELIGIBLE DEPENDENTS

- Your legal spouse---See definition of "Spouse".
- Your unmarried dependent children under age twenty (20) ---See definition of "Child".
- Your unmarried dependent children under age twenty-four (24) who are full-time students at an accredited school and who are dependent upon you for support ---See definition of "Student".

- A child who is under age eighteen (18) when he is placed with you for adoption and for whom you have assumed and retained a legal obligation for total or partial support in anticipation of adoption of such child.
- A child you must cover due to a Qualified Medical Child Support Order (QMCSO) subject to the conditions and limits of the law.
- Your unmarried disabled children over age twenty (20) if the child was disabled prior to attaining age twenty (20). You must provide satisfactory proof of the child's incapacity and dependency within thirty-one (31) days after the child's twentieth (20th) birthday. Continuing proof of disability and dependency will be required periodically.

Note: Anyone who is eligible for coverage as an employee will not be eligible for coverage as both an employee and as a dependent. Dependent children may not be covered by more than one employee. If both a husband and a wife are covered employees and the spouse carrying dependent coverage terminates coverage under the Plan, dependent coverage can be transferred to the spouse who remains covered by the Plan provided the employee continues to be an eligible employee. If both a husband and wife are covered employees and one terminates coverage with the Plan, he or she may be covered as a dependent under the remaining spouse's coverage.

SPECIAL ENROLLMENT PERIODS

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a Special Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period.

1. Individual losing other coverage. An Employee (or Dependent) who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions are met:

a. The Employee (or Dependent) was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
b. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
c. The coverage of the Employee (or Dependent) who has lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward the coverage were terminated.
d. The Employee requests enrollment in this Plan not later than thirty-one (31) days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above.

If the Employee (or Dependent) lost the other coverage as a result of the individual's failure to pay premiums or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

2. **Dependent beneficiaries.** A Dependent who is eligible, but not enrolled in this Plan, may enroll as a dependent beneficiary of a Covered Employee if each of the following conditions are met:

a. The Employee is a Covered Person under this Plan (or has met the waiting period applicable to becoming a Covered Person under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
b. A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of thirty-one (31) days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependents enrolled in the Special Enrollment Period will become effective:

1. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received.
2. In the case of a Dependent's birth, as of the date of the birth; or
3. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

DEPENDENT EFFECTIVE DATE OF COVERAGE

You must enroll your Dependents for coverage under this Plan by completing an enrollment form and authorizing any required contributions.

Dependent coverage begins on the date on which you become eligible for Plan benefits. If you apply for Dependent coverage on or before your eligibility date, or within thirty-one (31) days after your original eligibility date, coverage for your Dependents will begin on your original eligibility date.

If you acquire a Dependent after your original effective date of coverage, you must make written application for coverage for that Dependent within thirty-one (31) days of the date of the marriage, birth or adoption. If you apply for coverage for a Dependent within thirty-one (31) days following the date you acquire such Dependent, coverage for that Dependent will begin on the date of the marriage, birth or adoption. If you do not apply for coverage within thirty-one (31) days after the date you become eligible, or thirty-one (31) days after the date you acquire your first eligible dependent, or during a Special Enrollment Period, or if you previously elected to end Dependent coverage in the Plan, you may apply for coverage at any time. The effective date of coverage will be the first of the month following the date you complete an enrollment form and make any required contributions.

A newborn child will be covered at birth if you have Dependent coverage in effect at that time or if you make written application for Dependent coverage within thirty-one (31) days of the date of birth.

WHEN DEPENDENTS CEASE TO BE ELIGIBLE

All Plan coverage will terminate on the earliest of the following dates:

- In the case of all your Dependents, the date your coverage terminates or the Dependent ceases to be a Dependent as defined in this Plan.
- In the case of your Spouse, when you are legally separated or divorced.
- In the case of a Dependent Child other than a Student, attaining age twenty (20) or marriage or full-time employment, whichever occurs first.
- In the case of a Student, attaining age twenty-four (24) or when the child is no longer a full-time student or full-time employment or marriage, whichever occurs first.
- In the case of a Disabled Child, when the Dependent is no longer disabled or dependent upon you for support.
- The date the Dependent Coverage is discontinued under the Plan.
- The date the Dependent becomes covered as an employee.
- If your Dependent materially violates the terms of the Plan.
- If your Dependent participates in fraudulent or criminal behavior.
  Examples of fraudulent or criminal behavior include, but are not limited to:
    - Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts including using an identification card to

obtain goods or services which are not prescribed or ordered for him/her or to which he/she is otherwise not legally entitled.
    - Allowing any other person to use an identification card to obtain services.
    - Threatening or perpetrating violent acts against the Plan, a Provider, the Claims Administrator, or an employee of the Plan, Provider or Claims Administrator.
- If your Dependent knowingly misrepresents or gives false information on any enrollment application form which is material to the Plan's acceptance of such application.
- The date the Dependent enters the armed forces of any country on a full-time active duty basis.
- The end of the period for which you made any required contributions, if you fail to make any further required contributions.

Refer to the section in this Booklet entitled CONTINUATION RIGHTS for information regarding continued coverage after a Dependent ceases to be eligible under the Plan.

MEDICAL EXPENSE BENEFIT

To receive benefits under the Medical Expense Benefit, you must satisfy the Deductible amount shown on the Schedule of Benefits. Once you have satisfied the Deductible, benefits are payable as shown on the Schedule of Benefits.

Note: ***There are several benefits that do not require satisfaction of the Deductible and/or Coinsurance. Please refer to the Schedule of Benefits for further information.***

INDIVIDUAL DEDUCTIBLE

The Individual Deductible amount is shown on the Schedule of Benefits and is the total amount of Covered Medical Expenses that you or your dependents must satisfy in a Calendar Year before you or your dependents are eligible to receive the Medical Expense Benefit.

FAMILY DEDUCTIBLE

When Covered Family Members have satisfied the Family Deductible amount as shown on the Schedule of Benefits in a Calendar Year (no person can contribute more than the Individual Deductible amount), the Plan will not apply Medical Expense Deductibles to the remaining Covered Medical Expenses for all Covered Family Members for that Calendar Year.

CARRYOVER DEDUCTIBLE

Any Covered Medical Expenses incurred and applied toward the Individual and Family Deductible amounts during the last three (3) months of the year (October, November and December) are applied to the Individual and Family Deductible amounts for both the present and the following Calendar Years. Out-Of-Pocket reimbursement of 100% does not carry over.

COMMON ACCIDENT DEDUCTIBLE

If two (2) or more Covered Family Members are injured in the same accident, only one (1) Deductible will apply to all Covered Medical Expenses incurred as a result of that accident during the Calendar Year of the accident. The payment of benefits and the satisfaction of the Medical Expense Deductible as described apply only to those injuries sustained in the accident. Covered charges related to any other injury or illness will be payable on a separate basis as though this provision had not been included.

CO-INSURANCE FACTOR

After the Deductible is satisfied, the Plan will pay the applicable percentages (Coinsurance) of eligible Medical Expenses as shown on the Schedule of Benefits.

OUT-OF-POCKET MAXIMUM

If, in a Calendar Year, a Covered Person accumulates an Out-of-Pocket amount which equals the amount shown on the Schedule of Benefits, the Plan will pay 100% of any further Covered Medical Expenses incurred during the remainder of that Calendar Year.
PPO/Non-PPO expenses will be applied equally toward the satisfaction of both the PPO and Non-PPO Out-of-Pocket Maximums.

FAMILY OUT-OF-POCKET MAXIMUM

When Covered Family Members have satisfied the Family Out-of-Pocket Maximum amount shown on the Schedule of Benefits in a Calendar Year, the Plan will not apply the Co-insurance Factor to and will pay 100%, from that date forward, of any further Covered Medical Expenses for all Covered Family Members for the remainder of that Calendar Year.

Expenses Related To Satisfaction Of The Individual Or Family Deductibles, Prescription Drug Co-Payments, Charges In Excess Of Benefit Maximums, Charges In Excess Of Reasonable And Customary Fees, And Non-Compliance Penalties Do Not Accumulate Toward The Out-Of-Pocket Maximum.

Any Maximums Which Are Stated In Dollar Amounts, Number Of Days Or Number Of Treatments And Which Limit Either The Maximum Benefits Payable Or The Maximum Allowable Covered Expense Are The Combined Maximums Under The PPO And Non-PPO Level Of Benefits.

LIFETIME MAXIMUM BENEFITS

The Lifetime Maximum Benefit for all illnesses and injuries, per Covered Person, is shown on the Schedule of Benefits.

COVERED MEDICAL EXPENSES

The Plan provides Covered Persons with medical benefits. A summary of the benefits provided under the Plan is set forth in this document. This Plan will provide benefits in accordance with the applicable requirements of federal laws, such as COBRA, FMLA, the Health Insurance Portability and Accountability Act ("HIPAA"), the Mental Health Parity Act ("MHPA"), the Newborns' and Mothers' Health Protection Act ("NMHPA") and the Women's Health and Cancer Rights Act ("WHCRA").

The Plan covers only those health services and supplies that are deemed Medically Necessary by the Plan and not excluded under the exclusions and limitations set forth in this Section. Covered Transplants must be rendered by a Coventry Transplant Network Provider.

The following Section provides the health care services and supplies covered under this Plan. The Section is provided to assist Covered Persons with determining the level of coverage, limitations, and exclusions that apply for Covered Services when determined to be Medically Necessary, subject to the exclusions and limitations set forth in this Section. If a service is Medically Necessary but not specifically listed and not otherwise excluded, the service is not a Covered Service.

Reasonable and Customary charges incurred by, or on behalf of, a Covered Person for the following Medically Necessary items, if performed or prescribed by a physician for an injury or illness, subject to the Exclusions and Limitations of the Plan, are covered by the Medical Expense Benefit:

1. Hospital Room and Board including bed and board, general nursing care, meals and dietary services provided by the hospital. All semi-private or ward accommodations are covered.
    a. For private rooms, an allowance will be paid equal to the hospital's semi-private room charge.
    b. If the hospital only has private room facilities, private room charges will be considered as semi-private charges.
    c. If a private room is Medically Necessary for isolation purposes, the private room charge will be considered as semi-private.
    d. If Intensive Care, Coronary and Intermediate Care accommodations are Medically Necessary, the hospitals actual charges are covered.
2. Miscellaneous Hospital services and supplies, including equipment and medications provided to registered inpatients.
3. Hospital charges for Medically Necessary outpatient services.
4. Pre-admission testing within seventy-two (72) hours prior to admission.
5. Services and supplies furnished by an ambulatory surgical center.
6. Extended Care Facility services (refer to the specific section for coverage details).
7. Home Health Care services (refer to the specific section for coverage details).
8. Hospice Care services (refer to the specific section for coverage details).
9. Physician's services for surgery or other necessary medical care, whether rendered in the office, hospital, home, extended care facility or hospice.

10. Charges incurred for acupuncture but only if performed by a Medical Doctor as an alternative form of Medically Necessary anesthesia.
11. Licensed Psychologists' and licensed clinical Social Workers' professional medical services for the treatment of psychiatric disorders and substance abuse that would be covered if provided by a doctor of medicine (M.D.) and only when the psychologist or social worker is acting within the scope of his license.
12. Charges made by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for private duty nursing services when the attending physician certifies that such nursing care is Medically Necessary. ***Benefits are limited as shown on the Schedule of Benefits.***
13. Charges for physical and/or occupational therapy rendered by a licensed or registered physical or occupational therapist for the purposes of training to aid the restoration of normal physical functions lost due to an illness or injury.
14. Anesthesia and its administration.
15. Blood and blood plasma to the extent not donated or replaced.
16. X-ray and laboratory examinations for diagnostic or treatment purposes.
17. Allergy shots and allergy surveys.
18. Professional ambulance service to and from a hospital or extended care facility where medical care and treatment necessary for the illness or injury can be provided, or

a. Between hospitals and extended care facilities when a transfer is necessary to provide adequate care, or
b. Regularly scheduled airline or railroad or air ambulance within the continental United States and Canada to a hospital that has medical equipment not available locally for special inpatient treatment. Such transportation must be certified by the acting physician as necessary due to its emergency nature. Only charges incurred for the first trip to and from a hospital shall be included.

19. Durable Medical Equipment limited to the lesser of the purchase price or the total anticipated rental charges. **Pre-approval by the Claims Administrator is required.**
20. Chemotherapy or radiation therapy by x-ray, radium, radon or radioactive isotopes, or other such treatment or care recommended or prescribed by a Physician.
21. Renal dialysis treatment, including equipment and supplies when such services are provided in a hospital, dialysis facility or in the home under the supervision of a hospital or dialysis facility.
22. Charges for artificial limbs, eyes and other prosthetic devices to replace physical organs and body parts, including replacements which are Medically Necessary or required by pathological change or normal growth. Covered charges do not include expenses for the repair or replacement of damaged, lost or stolen devices.
23. Heart pacemaker.
24. Medical and surgical supplies including bandages and dressings.
25. Medically Necessary Jobst compression stockings (limited to two (2) pair per Calendar Year).
26. Medical supplies necessary to check, maintain and regulate blood glucose levels limited to the following items:

a. Glucose monitors;
b. Needles and syringes; and
c. Test Strips.

27. Casts, splints, crutches, cervical collars, head halters, traction apparatus and orthopedic braces.
28. Oxygen and rental of equipment for its administration.
29. The first pair of glasses or contact lenses, but not both, prescribed to treat glaucoma or keratoconus or resulting from cataract surgery.
30. Human Organ Transplants:

Coverage includes benefits for Medically Necessary expenses related to human organ, bone marrow and tissue transplants. Expenses incurred by a live organ donor, who is without insurance coverage and is not covered under this Plan, will be covered and limited to a maximum benefit of $10,000 for each organ transplant procurement. Donor screening tests are covered and are subject to a lifetime benefit maximum of $10,000 when performed at a Coventry Transplant Network participating facility approved by the Plan. Expenses incurred for organs obtained through an organ bank or from a cadaver and expenses for storage and transportation that are reasonable and customary, are covered under this Plan. If both the recipient and the donor are covered under this Plan, the expenses will be treated separately. The cost of any care, including complications, arising from an organ donation by a covered individual when the recipient is not a covered individual is Excluded. Medically Necessary organ transplant services must be Prior Authorized, performed at an approved Coventry Transplant Network participating facility, and not Experimental or Investigational. The Plan utilizes Centers of Excellence for transplant services. A list of these Centers of Excellence for each type of transplant is available from the Claims Administrator upon request. No coverage is provided for transplant services obtained outside of the Coventry Transplant Network.

31. Restorative or rehabilitative speech therapy by a qualified speech therapist when such therapy is administered:
    a. To a Covered Person whose previously unimpaired speech is affected by an illness or injury; or
    b. To a Dependent Child as part of such Child's treatment for cerebral palsy or following surgery to correct a congenital anomaly of such Child.
32. Charges for reconstructive or cosmetic surgery provided the following conditions are met:
    a. The surgery must be required to correct a condition that results from an illness or injury; or
    b. The surgery is required to correct the congenital anomaly of a Dependent Child.
    c. **Cosmetic surgery related to acne is not a covered expense.**
33. Charges for the following expenses related to breast reconstruction in connection with a mastectomy in a manner determined in consultation with the attending physician and the patient:
    a. Reconstruction of the breast on which the mastectomy has been performed;
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    c. Prostheses and physical complications in all stages of mastectomy, including lymphedemas.

34. Charges for obstetrical care are paid on the same basis as any other illness, including prenatal care, pregnancy, miscarriages and therapeutic abortions. Benefits ***ARE NOT*** provided for the pregnancy of a Dependent Child; ***OR FOR*** the newborn unless and until the Employee (the grandparent) becomes the legal guardian for that child. Coverage for a hospital stay following a normal vaginal delivery will be forty-eight (48) hours for both the mother (if an Employee or Covered Dependent Spouse) and the newborn child unless a shorter stay is agreed to by both the mother and her attending physician. Coverage for a hospital stay in connection with childbirth following a Caesarean section will be ninety-six (96) hours for both the mother (if an Employee or Covered Dependent Spouse) and the newborn child unless a shorter stay is agreed to by both the mother and her attending physician.
35. Medically Necessary abortions and complications which arise from an abortion.
36. Charges incurred in connection with a Birthing Center (in lieu of hospital confinement) and Medically Necessary supplies furnished to the mother and necessary supplies furnished to the covered newborn child.
37. Routine newborn care while hospital confined, including hospital nursery care and other hospital services and supplies and physicians charges for pediatric care and circumcision. ***Benefits will be covered with the mother's charges.***
38. **PPO Providers Only -** Well-baby and well-child care for dependent children.
39. **PPO Providers Only -** Routine examinations including gynecological exams.
40. Mammograms and pap smears.
41. **PPO Providers Only -** Routine pediatric and adult immunizations.
42. Charges for inoculations when recommended by a physician because of exposure to a contagious disease.
43. Voluntary sterilizations, but not the reversal of such procedures.
44. Chiropractic care, by any name called, including all professional services for the detection and correction by manual or mechanical means (with or without the application of treatment modalities such as, but not limited to diathermy, ultrasound, heat and cold) of the spinal skeletal system and/or surrounding tissue to restore proper articulation of joints, alignment of bones or nerve functions. Such care may not be considered a covered expense if it is determined to be maintenance palliative. ***Benefits are limited to the amount shown on the Schedule of Benefits.***
45. Charges for the following obesity treatment, ***to the lifetime maximum shown on the Schedule of Benefits,*** when it has been determined that such services are Medically Necessary:

a. Services and supplies related to an ileojejunal or gastric shunt operation;

b. Inpatient hospital treatment for weight reduction when the attending physician certifies that the hospitalization and care for the weight reduction is medically required as the obesity creates a clear and immediate threat to the life of the patient; and

c. If the obesity is caused solely by a medical condition and not by personality or psychological disorders or problems of the patient.

46. Drugs and medications requiring a physician's written prescription (including insulin and insulin syringes), excluding birth control drugs **which are prescribed solely for contraceptive purposes,** contraceptive devices and over-the-counter medications. (Drugs and medications purchased through the Prescription Drug Plan will be covered as

shown on the Schedule of Benefits. Maintenance medications obtained through a Mail Order Prescription Drug Plan are payable as shown on the Schedule of Benefits.)

47. Prenatal vitamins.

48. Charges for the diagnosis and treatment of temporomandibular joint dysfunction (TMJ). ***Benefits are limited to the amount shown on the Schedule of Benefits.***

49. Expenses for the following dental related services and supplies:

    a. Treatment for the repair or alleviation of damage to sound natural teeth due to an accidental injury, other than from eating or chewing, or treatment of an injury to the jaw due to an injury. Treatment must be rendered within six (6) months of the injury.

    b. Excision of a tumor, cyst, or foreign body of the oral cavity and related anesthesia.

    c. Biopsies of the oral cavity and related anesthesia.

    d. Removal of partial and full bone impacted teeth and related anesthesia.

    e. Expenses billed by a hospital for inpatient and outpatient dental services will be covered if the Covered Person has a serious medical condition that requires hospitalization.

50. Inpatient and Outpatient Psychiatric and Substance Abuse:

    Expenses are subject to the Deductible, Co-Insurance percentages and Benefit Maximums shown on the Schedule of Benefits.

EXTENDED CARE FACILITY

The Plan will provide benefits for charges made by an Extended Care Facility for convalescing from an illness or injury. Covered charges include:

- Room and board including charges for services such as general nursing care made in connection with room occupancy. The charge for daily room and board is limited to the semi-private room rate,
- Use of special treatment rooms, x-ray and laboratory examination, physical, occupational, or speech therapy and other medical services customarily provided by an Extended Care Facility except private duty or special nursing services or physician's services,
- Drugs, biological solutions, dressings, casts and other Medically Necessary supplies.

Convalescent Period - A "convalescent period" begins on the first day an individual is confined in an Extended Care Facility if:

- He becomes confined in a hospital for at least three (3) consecutive days for treatment of an illness or injury and,
- He is confined in the Extended Care Facility within thirty (30) days after the end of that hospital confinement, and
- The attending physician certified that twenty-four (24) hour nursing care is necessary for the recuperation from an injury or illness which required the hospital confinement, and
- He is confined in the Extended Care Facility to receive skilled nursing and physical restorative services for convalescence from the illness or injury that caused that hospital confinement.

Even though there may be several non-consecutive confinements in an Extended Care Facility, the "Convalescent Period" will continue until there has been a period of ninety (90) consecutive days during which the individual has been free of confinement in a hospital, Extended Care Facility or other institution providing nursing care.

HOME HEALTH CARE

The Plan will provide benefits for charges made by a licensed Home Health Care Agency for the following services and supplies furnished to a Covered Person in his home, or the place of residence used as such person's home for the duration of his illness or injury, for care in accordance with a Home Health Care Plan.

Home Health Care visits are limited to a maximum of one hundred (100) visits in any calendar year. One (1) visit of home health care is considered to be care received in one (1) calendar day, not to exceed eight (8) hours during any twenty-four (24) hour period. Benefits in excess of the stated limitations are subject to prior approval by the Claims Administrator.

The care must be administered in lieu of a Hospital or Extended Care Facility confinement. Expenses for, but not limited to, the following are covered under this benefit:

- Part-time or intermittent nursing care by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.).
- Part-time or intermittent home health aide services.
- Physical, occupational, respiratory and speech therapy.
- Medical supplies, drugs and medicines prescribed by a physician, and x-ray and laboratory services.
- Medical social services.
- Nutritional counseling.
- Renal Dialysis

The following Home Health Care Expenses are not covered under the Plan:

- Meals, personal comfort items and housekeeping services.
- Services or supplies not prescribed in the Home Health Care Plan.
- Services of a person who ordinarily resides in your home, or who is a member of your or your spouse's family.
- Transportation services.
- Treatment of psychiatric conditions of any type, including substance abuse.

HOSPICE CARE

The Plan will provide benefits for care received through a home or inpatient Hospice Care program to which a terminally ill patient was referred by his attending physician. Expenses for, but not limited to, the following are covered under this benefit:

- Inpatient Hospice, limited to the semi-private room rate.
- Part-time or intermittent nursing care by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.).
- Physical, occupational, respiratory and speech therapy.

- Medical social services.
- Part-time or intermittent home health aide services.
- Medical supplies, drugs, and medicines prescribed by a physician, and x-ray and laboratory services.
- Physician's services.
- Dietary counseling.
- Bereavement counseling for immediate family members.

The following Hospice Care expenses are not covered under the Plan:

- Transportation services.
- Financial or legal counseling for estate planning or drafting a will.

SPECIAL COVERAGES

SUPPLEMENTAL ACCIDENT BENEFIT

If you or your covered dependent have an accidental injury and treatment commences within seventy-two (72) hours of the accident, the Plan will provide benefits for the treatment rendered within ninety (90) days following the accident, up to the amount shown on the Schedule of Benefits. Covered expenses will include, but are not limited to, the following:

- Hospital charges for room and board and necessary services and supplies.
- Physician's professional medical and surgical services.
- Diagnostic x-ray and diagnostic laboratory examinations.
- Private-duty nursing services by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) when the attending physician certifies that nursing care is necessary.
- Prescription drugs, surgical dressings, braces, crutches, artificial limbs, and artificial eyes.
- Rental of durable medical equipment.
- Professional ambulance service to the nearest hospital where treatment can be rendered.

Expenses related to the following are not covered under this benefit:

- Illness or pregnancy.
- Eye refractions, eyeglass frames and lenses, contact lenses or their fittings;
- Dental treatment, x-rays or surgery except from injury to sound natural teeth.

Charges in excess of the Benefit Maximum are payable as any other covered expense.

SECOND SURGICAL OPINION BENEFIT

If your physician recommends non-emergency surgery, meaning surgery that can be postponed without causing undue risk to the patient, you, a member of your family or your physician must contact the Utilization Review Service. The Utilization Review Service will evaluate the information provided and advise you and/or your physician if a second opinion is required.

Pre-Surgical Review is not required for minor surgical and diagnostic procedures performed in a physician's office.

The Plan will pay for the physician's reasonable and customary charge for a second surgical opinion if required by the Utilization Review Service. The Second Surgical opinion Benefit also covers the cost of any additional x-ray and laboratory tests, which the second physician may order. If the second surgical opinion does not confirm the advisability of the proposed surgery, a third opinion may be arranged and will be paid for in the same manner as the second.

An opinion confirming the advisability of surgery may give you and your dependents greater peace of mind, and a non-confirming opinion may provide an alternative non-surgical method of treatment for the medical condition. If you do not use the Benefit, you will be passing up the chance to get additional medical advice at no cost to you or your dependents.

If you choose to proceed with an elective surgical procedure without contacting the Utilization Review Service for prior authorization, or without obtaining a second surgical opinion when required by the Utilization Review Service, or if you choose to proceed with elective surgery when the necessity has not been confirmed by the second (or third) opinion, **all covered expenses related to the surgery will be payable at 50%, subject to any applicable deductible. THIS NON-COMPLIANCE PENALTY WILL NOT ACCUMULATE TOWARD THE REQUIRED DEDUCTIBLES OR THE OUT-OF-POCKET MAXIMUMS.**

PRESCRIPTION DRUG PROGRAM

The Plan provides benefits for eligible prescription drugs and medicines through a Prescription Drug Program. Present your I.D. card to the participating pharmacist at the time you fill or refill a prescription for yourself or your covered dependent. You will pay a co-payment for each prescription, or the actual cost if less than the co-payment. The co-payment amounts are shown on the Schedule of Benefits. While members should try to use a participating pharmacy for prescriptions, members can purchase and submit their prescriptions with receipts for reimbursement. Maintenance prescription drugs and medications requiring a physician's written prescription are available through the Mail Order Prescription Drug Program. For further details, refer to the Mail Order brochure available from the City Clerk's Office.

MENTAL HEALTH, ALCOHOL AND DRUG ABUSE SERVICES BENEFITS

The Plan will coordinate, determine the Medical Necessity of and Preauthorize the diagnosis and treatment of all mental illnesses, psychiatric conditions, and alcoholism and substance abuse issues ("Mental Health and Substance Abuse"). Except in the event of an emergency, Prior Authorization for all in-patient Mental Health and Substance Abuse must be obtained before receiving services. You may obtain Prior Authorization by contacting the Claims Administrator's Customer Service Department. All mental health, alcoholism and substance abuse benefits are subject to utilization management. If you have any questions about your Mental Health and Substance Abuse coverage or the appropriate way to access coverage, please contact the Claims Administrator at (866) 557-8751.

The following Mental Health and Substance Abuse services are covered:

Outpatient Services. Medically Necessary individual outpatient mental health or rehabilitation care visits to qualified Physicians, duly licensed clinical psychologists or clinical social workers as may be necessary and appropriate for evaluation, short-term treatment and crisis intervention services. You should consult your Schedule of Benefits to determine the amount of your payment responsibility per visit and any applicable limitations or benefit maximums. An outpatient visit for the purpose of medication management will not be counted toward your visit limits. Outpatient visits for mental health are covered under the same terms and conditions as outpatient visits for the treatment of physical illness.

Inpatient Services. Your coverage for treatment of serious medically necessary mental illness or rehabilitation care at an inpatient facility or hospital shall be under the same terms and conditions for coverage for hospital or medical expenses related to other illnesses and diseases. Inpatient services are subject to Prior Authorization by the Plan except in the event of an Emergency. You should consult your Schedule of Benefits to determine the amount of your payment responsibility per hospitalization and any applicable limitations or benefit maximums.

Diagnosis, detoxification and treatment of the medical complications of the abuse of or addiction to alcohol or drugs on either an inpatient or outpatient basis. Coverage for these inpatient hospital services is the same as coverage for non-mental health inpatient services for any other illness, condition or disorder.

MEDICAL EXPENSE EXCLUSIONS AND LIMITATIONS

In addition to Exclusions and Limitations stated elsewhere in this Plan, the Medical Provisions of this Plan do not cover any loss caused by, incurred for or resulting from:

1. Hospitalization, services or supplies, which are not Medically Necessary.
2. Charges for experimental drugs that:
    a. Are not commercially available for purchase;
    b. Are not approved by the Food and Drug Administration (FDA) for general use;
    c. Are not being used for the condition or illness for which they received FDA approval.
    d. Are not recognized by state or national medical communities, Medicare, Medicaid or other governmental financed programs.
3. Charges for any care, treatment, services or supplies that are:
    a. Not approved or accepted as essential to the treatment of any illness or injury by any of the following: the American Medical Association, the U.S. Surgeon General, the U.S. Department of Public Health, or the National Institute of Health; or
    b. Not recognized by the medical community as potentially safe and efficacious for the care and treatment of the injury or illness.
4. Custodial care - That type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed and supervision over medication which can normally be self-administered. ***This limitation does not apply to charges related to Hospice care or Home Health care.***
5. Milieu therapy or any confinement in an institution primarily to change or control one's environment.
6. Charges for acupuncture or hypnosis except as shown as a covered expense.
7. Growth hormone therapy ***except under the direction of a pediatric endocrinologist and documentation of pituitary insufficiency. Treatment must be authorized by the Plan Administrator.***
8. Hormone implantation therapy and thermography.
9. Services or supplies received during an inpatient stay when the stay is primarily for behavioral problems or social maladjustment or other antisocial actions which are not specifically the result of mental illness.
10. Reconstructive or cosmetic surgery, except for reconstructive surgery following a mastectomy or the correction of congenital deformities or conditions resulting from an illness or injury. Cosmetic surgery related to acne is not a covered expense.
11. Personal hygiene, comfort or convenience items that do not qualify as Durable Medical Equipment and are generally useful to the Covered Person's household, including but not limited to:
    a. All types of beds, other than hospital type beds that qualify as a Covered Expense;
    b. Air conditioners, humidifiers, air cleaners, filtration units and related apparatus;

c. Whirlpools, saunas, swimming pools and related apparatus;
d. Medical equipment generally used only by Physicians in their work;
e. Vans and van lifts, stair lifts and similar other ambulatory apparatus;
f. Exercise bicycles and other types of physical fitness equipment.

12. Special braces, splints, equipment, appliances, battery or anatomically controlled implants unless Medically Necessary.
13. Expenses for physical therapy or occupational therapy when it is not a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function.
14. Speech therapy unless it is required because of a physical impairment caused by an illness, injury, or congenital deformity.
15. Recreational or educational therapy or forms of non-medical self-care or self-help training and any diagnostic testing.
16. Treatment of pregnancy or any complications thereof, for a dependent child.
17. Elective abortions or any complications thereof.
18. Charges for services provided by a Social Worker, except as shown as a covered expense.
19. Hospital charges that are incurred prior to the first Monday of a confinement that begins on a Friday, Saturday or Sunday, unless:

a. Such confinement is due to a Medical Emergency; or
b. Surgery is performed within twenty-four (24) hours after such confinement begins.

20. Charges for birth control drugs or contraceptive devices.
21. Charges for nutritional supplements, vitamins (except prenatal vitamins)or minerals.
22. Services or supplies for the purpose of nicotine cessation.
23. Charges for services to restore or enhance fertility, including, but not limited to, artificial insemination, in vitro fertilization, embryo transfer procedures and sterilization reversal.
24. Charges for treatment of hair loss for any reason.
25. Charges for any of the following items, including their prescription or fitting, except as shown as a covered expense:

a. Hearing aids;
b. Optical or visual aids, including contact lenses and eyeglasses;
c. Wigs and hair transplants;
d. Orthopedic shoes;
e. Any examination to determine the need for, or the proper adjustments of any item listed above; and
f. Any procedure or surgical procedure to correct refractive error.

26. Charges for testing, training or rehabilitation for educational, developmental or vocational purposes.
27. Charges for marriage counseling and/or sexual therapy.
28. Charges incurred for the treatment of obesity except as shown as a covered expense.
29. Charges for treatment of a learning disability.
30. Foot care resulting from:

a. Weak, strained, unstable, unbalanced or flat feet;
b. Metatarsalgia or bunions, unless an open cutting operation is performed; or

c. Treatment of corns, calluses or toenails, unless at least part of the nail root is removed, unless necessary for metabolic or peripheralvascular disease; or
d. Supportive devices (orthotics) for such conditions.

31. The care and treatment of the teeth, gums or alveolar process, and dentures, appliances or supplies used in such care and treatment, except as shown as covered expenses.
32. Charges for or related to penile implant devices and surgery, and any related services or any related complications, except when Medically Necessary.
33. Travel for health.
34. Routine or periodic health examinations or immunizations except as shown as a covered expense.
35. Charges in connection with an injury or illness arising out of a Covered Person's operating or riding any kind of commercial aircraft except as a fare-paying passenger on a regularly scheduled flight.
36. Charges for services, supplies or treatment of an injury due to an accident which occurred as a result of a Covered Person's negligent or illegal use of alcohol or drugs will be limited to the maximum shown on the Schedule of Benefits. This limitation does not apply to prescription drugs when consumed as prescribed by a physician and in accordance with the instructions and precautions given by the pharmacist.
37. Christian Science services.
38. Charges for chelation (metallic ion) therapy.
39. Any item shown in General Exclusions and Limitations.

GENERAL EXCLUSIONS AND LIMITATIONS

This Plan does not cover and no benefits shall be paid for any loss caused by, incurred for or resulting from:
1. Charges in excess of Reasonable and Customary fees.
2. Services or supplies received from either an Employee's or Employee's spouse's relative, any individual who ordinarily resides in the Employee's home or any such similar person.
3. Charges for failure to keep a scheduled visit or charges for completion of a claim form or for medical records.
4. Charges for telephone conversations.
5. Services or supplies for which there is no legal obligation to pay or for which no charge would be made in the absence of this coverage.
6. Charges for or in connection with an illness or injury arising out of or in the course of any employment for wage, profit or gain.
7. Charges for or in connection with an illness or injury for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupation Disease Law or similar Local, State or Federal Statutes under which the Covered Person is entitled to benefits.
8. Charges for or in connection with an injury or illness arising out of or in the course of war, declared or undeclared, service in any military, naval, or air force of any country or international organization, or in any auxiliary or civilian noncombatant unit serving with such forces.

9. Services or supplies that are provided by the local, state or federal government and that part of the charges for any services or supplies for which payment is provided or available from the local, state or federal government (i.e., Medicare) whether or not that payment is received, except as otherwise provided by law.
10. Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are experimental or investigational in nature.
11. Services for or in connection with an intentional self-inflicted injury or illness while sane or insane.
12. Charges for or in connection with an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a felony.
13. Services or supplies furnished by a hospital owned or operated by the United States Government or agency thereof, or furnished by a physician employed by the United States Government or agency thereof, to the extent permitted by law.
14. Charges incurred outside the United States if:

a. The Covered Person traveled to such location to obtain medical services, drugs or supplies; or
b. Such services, drugs or supplies are unavailable or illegal in the United States.

15. Charges for services required by any employer as a condition of employment, or rendered through a medical department, clinic or other similar facility provided by an employer or by a union employee benefit association or similar group of which the person is a member.
16. Health examinations required for the use of a third party.
17. Treatment of any condition not caused by illness or not resulting from bodily injury, except as shown as a covered expense.
18. Expenses submitted more than twelve (12) months after the date incurred, except that failure to submit within the stated time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to submit such claim in a timely manner and that the claim was submitted as soon as was reasonably possible.
19. Charges in excess of the benefits specified in this Plan.

OTHER HEALTH BENEFIT PLAN INFORMATION

COORDINATION OF BENEFITS

Introduction

This coordination of benefits ("**COB**") provision applies when a Covered Person has health care coverage under more than one Plan. "Plan" is defined below. The order of benefit determination rules below determine which Plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group Plans do not exceed 100% of the total Allowable Expense.

Definitions

"Allowable Expense" means any necessary, reasonable and customary item of expense for heath care, at least a portion of which is covered by one or more Plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary either in terms of generally accepted medical practice or as specifically defined in the Plan. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

"**Claim Determination Period**" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this coordination of benefits section or a similar provision takes effect.

"**Plan**", for purposes of this coordination of benefits section only, means any of the following which provides benefits or services for care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured. This includes pre-payment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a governmental Plan or coverage that is required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42 USCA 301, *et seq.*) as amended from time to time). It also does not include any Plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. In the event Medicaid or any other social program directs services, the Plan will cover the resulting charges only if you have followed the requirements as set forth in this Plan Document.
- Each contract or other arrangement for coverage under the above two paragraphs is a separate Plan. Also, if an arrangement has two parts and coordination of benefits rules apply only to one of the two, each of the parts is a separate Plan.

- Plan also includes the medical benefits coverage, including any funds available under uninsured motorist or underinsured motorist provisions, in group automobile contracts, in group or individual automobile "no-fault" contracts, in traditional automobile "fault" type contracts, individual or otherwise, to the extent benefits provided under such contracts must be determined without taking the existence of any other Plan into consideration.
- Group, blanket or franchise coverage; or
- Hospital or medical service organization on a group basis, group practice and other group prepayment plans; or
- A licensed Health Maintenance Organization (HMO); or
- Any coverage under a labor-management trusted plan, union welfare plan, employer organization plan, employee benefit organization plan or such similar plan.

"**Primary Plan/Secondary Plan**" is defined by the order of benefit determination rules, which state whether This Plan is a Primary Plan or Secondary Plan (another Plan covering the Member). When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of benefits received from the Primary Plan. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

"**This Plan**" means the Plan offered by the Plan Sponsor that provides benefits for health care expenses as described in this Plan Document.

Effect on Benefits

If the order of benefit determination rules as set for below are applied and it is determined that This Plan determines its benefits before another Plan, the benefits of This Plan shall not be reduced and shall be paid without regard to the other Plan.

If the order of benefit determination rules are applied and it is determined that another Plan determines its benefits first, the benefits of This Plan will be reduced when the sum of:

- The benefits that would be payable for the Allowable Expense under This Plan in the absence of this coordination of benefits section; and

- The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this coordination of benefits section, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

- When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

➢ **Note:** Reimbursement will not exceed one hundred percent of the total Allowable Expenses incurred under This Plan and any other Plan.

Order of Benefit Determination Rules.

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

Plan with No Coordination of Benefits Provisions. A Plan which contains no provisions for coordination of benefits is considered to pay its benefits before a Plan that contains such a provision.

Non-Dependent/Dependent. The benefits of a Plan which covers the person as an employee, Covered Person or Subscriber (that is, other than as a Dependent) shall be primary over a Plan which covers the person as a Dependent, except that if the person is also a Medicare beneficiary, Medicare is:

i. Secondary to the Plan covering the person as a Dependent; and
ii. Primary to the Plan covering the person as other than a Dependent (for example, a retired employee)

Dependent Child/Parents Not Separated or Divorced. Except as stated in the subparagraph below, when This Plan and another Plan cover the same child as a Dependent of different persons called "parents":

i. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
ii. If both parents have the same birthday, the benefits of the Plan, which covered one parent longer, are determined before those of the Plan which covered the other parent for a shorter period of time. However, if the other Plan does not have the rule described in subsection (i) immediately above, but instead has a rule based upon the gender of the parent, 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.

Dependent Child/Separated or Divorced. 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:

i. First, the Plan of the parent with custody of the child;
ii. Then, the Plan of the spouse of the parent with custody of the child; and
iii. Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply to any Claim Determination Period or contract year during which any benefits are actually paid or provided before the entity has actual knowledge.

Dependent Child/Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in the subparagraph above.

Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (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 will be ignored.

Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:

i. The Plan covering the person as an employee, Covered Person or Subscriber (or as that person's dependent) will be primary;
ii. The benefits under the continuation coverage will be secondary.

Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, Covered Person or Subscriber longer are determined before the benefits of the Plan which covered that person for the shorter term.

Right to Necessary Information

The Plan may need certain facts in order to apply the above coordination of benefits rules. The Plan has the right to decide which facts it needs. You or any other person claiming benefits under This Plan agree to notify the Plan of the existence of any other group coverage and to provide any information Plan may need to coordinate the insurance benefits and pay the claim. The Plan may get needed facts from or give them to any other organization or person, with or without the consent of any person.

Right to Recover

If the amount of the payments made by the Plan through its Claims Administrator is more than it should have paid under this coordination of benefits provision, it has the right to recover the excess from any person or organization to whom, or for whom, the excess payment has been made. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Facility of Payment

Sometimes a payment made under another Plan may include an amount, which should have been paid under This Plan. If this happens, the Plan may adjust the payment and specifically reserves the right to pay that amount to the organization which made that payment. Any amount paid to the organization will then be treated as a benefit paid under This Plan. Neither the Plan nor the Claims Administrator will ~~not~~ be liable for payment of that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Coordination of Benefits with Medicare

Active Employees and Spouses Age 65 and Older

- If an employee is eligible for Medicare and works for an employer with fewer than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding Health Plan Year, then Medicare will be the primary payer. Medicare will pay its benefits first. This Health Plan will pay benefits on a secondary basis.

- If an employee works for an employer with more than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding Health Plan Year, this Health Plan will be primary. However, an Employee may decline coverage under this Health Plan and elect Medicare as primary. In this instance, this Health Plan, by law, cannot pay benefits secondary to Medicare for Medicare covered services. You will continue to be covered by this Health Plan as primary unless you (a) notify us, in writing, that you do not want benefits under this Health Plan or (b) otherwise cease to be eligible for benefits under this Health Plan.

Disability

- If you are under age 65 and eligible for Medicare due to disability, and actively work for an employer with fewer than 100 employees, then Medicare is the primary payer. This Health Plan will pay benefits on a secondary basis.

- If you are age 65 or older and actively work for an employer with at least 100 employees and you become entitled to benefits under Medicare due to disability (other than ESRD as discussed below) this Health Plan will be primary for you and your eligible Dependents and Medicare will pay benefits on a secondary basis.

End Stage Renal Disease (ESRD)

If you are entitled to Medicare due to End Stage Renal Disease (ESRD), this Health Plan will be primary for the first 30 months. If this Health Plan is currently paying benefits as secondary, this Health Plan will remain secondary upon your entitlement to Medicare due to ESRD.

Coordination of Benefits for Retirees

If you are retired and you or one of your Dependents is covered by Medicare Part A and/or Part B (or would have been covered if complete and timely application had been made), benefits otherwise payable for treatment or services described in this Agreement will be paid after:

- Amounts payable are paid for treatment or services by Medicare Parts A and/or Part B;
- Amounts that would have been payable (paid) for treatment or service by Medicare Parts A and/or Part B, if you or your Dependents had been covered by Medicare; or
- Amounts paid under all other Plans in which you participate.

Right to Receive and Release Needed Information

By accepting Coverage under this Agreement, you agree to:

- Provide the Plan with information about other coverage and promptly notify us of any coverage changes;
- Give the Plan the right to obtain information as needed from others to coordinate benefits; and
- Return any excess amounts to the Plan if it through its Claims Administrator makes a payment and later find that the other Coverage should have been primary.

SUBROGATION

If this Plan provides for Injury, Illness or other loss (the Injury) sustained by the Covered Person (the Injured Party), this Plan will be subrogated to all rights of recovery the Injured Party, his heirs, guardians, executors or other representatives may have arising from the Injury. This Plan's subrogation rights include, but are not limited to, a right of

recovery against any person, insurance company or other entity that is in any way responsible for providing compensation or other payment as a result of the Injury or Illness or other loss. This Plan's subrogation rights include a right of recovery under no fault, personal injury protection, Medpay, financial responsibility, uninsured motorist, underinsured motorist insurance coverage, medical reimbursement insurance, specific risk insurance, "school" or "team" insurance, workers' compensation and third party liability.

The Injured Party and any person acting on his behalf may be requested to provide this Plan with information this Plan believes necessary to protect its right of subrogation. If such a request is made, the Injured Party and any person acting on his behalf are obligated to provide this Plan with such information and to do nothing to prejudice this Plan's right of subrogation. Notification of this Plan's right of subrogation is sufficient to protect this Plan's subrogation interest and the initiation of or intervention in any legal action shall not be required or necessary to establish this Plan's right of subrogation. This Plan shall be entitled to assert a lien against third parties, insurers, attorneys and any other persons when and as necessary in order to protect the rights of the beneficiaries of this Plan or Plan assets. The amount of this Plan's subrogation interest shall be deducted first from any recovery by or on behalf of the Injured Party or any person acting on his behalf. This Plan shall not be responsible for expenses or fees incurred in connection with any recovery unless this Plan shall have agreed in writing to pay a portion of those expenses or fees. This Plan reserves the right to initiate an independent action in the name of the Injured Party or his representative to recover its subrogation interest.

HOW SUBROGATION WORKS

When a Covered Person submits an injury claim to this Plan, the Claims Administrator will request additional information regarding how, when and where the Injury occurred and the names and addresses of all persons and insurers involved. A Subrogation and Assignment of Benefits Agreement will be sent to the Covered Person for his signature. **Benefits will be withheld until the information and signed Agreement are received.**

It is important that the Covered Person respond to this request so this Plan will have the information necessary to process the bills and protect its right of subrogation. If the Claims Administrator believes another party, insurer or other entity may be responsible for providing compensation or other payment regarding the Injury, it will notify the appropriate party of this Plan's subrogation interest.

If there is a recovery from another party or insurer, this Plan will be reimbursed first out of such recovery. If the Covered Person has already recovered from the other party or an insurer, this Plan may require reimbursement from the Covered Person for the amount of benefits paid by this Plan for the Injury. This Plan's subrogation right is subject to ERISA, which preempts individual state law.

CONTINUATION RIGHTS

Continuation of Coverage Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA requires that the Plan offer eligible Qualified Beneficiaries the opportunity to pay for a temporary extension of health care coverage in instances where coverage under the Plan would otherwise end, in accordance with the provisions of federal law. **Note: Continuation coverage for Covered Persons who selected continuation coverage under a prior plan which was replaced by coverage under this Plan shall terminate as scheduled under the prior plan or in accordance with the terminating events set forth below, whichever is earlier.** A Qualified Beneficiary does not have to show that he/she is insurable to choose COBRA continuation coverage. COBRA continuation is provided, subject to the person's eligibility for coverage under the Plan.

Employees

Covered Employees who lose eligibility for health care payment under the following conditions can continue coverage in accordance with this Section:

- Termination of employment (except for gross misconduct, whether voluntarily or involuntarily).
- Layoff or reduction in hours of employment, resulting in loss of coverage.
- Notwithstanding the foregoing, a Qualified Beneficiary (including members of the Employee's family) is not entitled to elect continuation coverage if the Employee's termination of employment is for gross misconduct (including, but not limited to, fraud, theft, embezzlement, gross negligence, malfeasance or misfeasance) as determined by the Plan Administrator or its delegate, in its sole discretion, pursuant to a uniform nondiscriminatory policy.

Spouses

A spouse who is a Dependent of a Covered Employee will have the right to continue coverage in accordance with this Section if coverage is lost for any of the following reasons:

- The death of the Covered Employee.
- Termination of the Covered Employee's employment (other than for gross misconduct) or reduction in the Covered Employee's hours of employment.
- Divorce or legal separation from the Covered Employee.
- The Covered Employee becomes entitled to Medicare.

Dependent Children

The Dependent child of a Covered Employee has the right to continue coverage in accordance with this section if the coverage is lost for any of the following reasons:

- The death of the Covered Employee.
- Termination of the Covered Employee's employment (other than for gross misconduct) or reduction in the Covered Employee's hours of employment.

- Divorce or legal separation of the Covered Employee.
- The Covered Employee becomes entitled to Medicare.
- The Dependent child ceases to satisfy the Plan Sponsor's eligibility rules for Dependent status.

Newborn or Adopted Children

If, during the period of COBRA coverage, a Covered Employee or an eligible Dependent spouse gives birth to a child, or if a child is placed with a Covered Employee or Dependent spouse for adoption, the Covered Employee may elect COBRA continuation coverage for that child. Coverage for the newborn or adopted child will continue for the same period of time that coverage for any other Dependent children is or could have been provided.

Special Enrollment Rules for Qualified Beneficiaries

A Qualified Beneficiary receiving COBRA continuation coverage is also entitled to enroll family Covered Persons in the Plan under the Special Enrollment rules set forth in this document the same as if the Qualified Beneficiary was an employee or participant within the meaning of those rules.

Length of Coverage

A Qualified Beneficiary's coverage may continue under COBRA as follows:

- Coverage for the Covered Employee and Dependent(s) may be continued for up to eighteen (18) months, if coverage is terminated due to the Covered Employee's:
  (1) termination of employment (other than for gross misconduct) or
  (2) reduced work hours

  The 18-month period of continuation coverage may be extended an additional eleven (11) months for the Covered Employee or family Dependent if, within sixty (60) days from the date of the event described in (1) or (2) above, the Social Security Administration determined that the Covered Employee or family Dependent was disabled. If the disabled individual has non-disabled family Covered Persons who are entitled to COBRA, the non-disabled family Covered Persons are also entitled to extend their COBRA continuation coverage from eighteen (18) to twenty-nine (29) months. The required contribution for the eleven (11) month extension may be increased, up to one hundred fifty percent (150%) of the cost of the Plan Sponsor's cost of providing coverage under the Plan for "similarly situated" covered individuals.

  Proof of disability must be provided within sixty (60) days from the date the Social Security Administration makes the determination and within the initial eighteen (18) month period of continuation coverage.

If, during the initial eighteen (18) month period, the Social Security Administration determines that the affected individual is no longer disabled, the eleven (11) month extension does not apply. If the Social Security Administration determines that the affected individual is no longer disabled after the initial eighteen (18) month period, the period of continuation coverage ends the first day of the month that begins more than thirty (30) days after the date of the Social Security Administration's determination, provided the period of continuation coverage does not exceed twenty-nine (29) months.

- Coverage for eligible Dependents may be continued up to a maximum of thirty-six (36) months, if coverage is terminated due to:
  (1) the Covered Employee's death;
  (2) the Covered Employee's divorce or legal separation; or
  (3) a Dependent child ceases to satisfy rules for Dependent status.

- If a Covered Employee becomes entitled to Medicare, and within eighteen (18) months of becoming entitled to Medicare, he/she becomes entitled to COBRA continuation coverage due to termination of employment (other than for gross misconduct) or reduction in work hours, coverage for the Qualified Beneficiary's Dependents may be continued for up to thirty-six (36) months from the date the Covered Employee became entitled to Medicare.

Notification and Election Requirements

Each Covered Employee and each eligible Dependent has the responsibility to inform the Plan Sponsor of a divorce, legal separation, Medicare eligibility or a child losing dependent status under the Plan within sixty (60) days of the qualifying event. Failure to provide this notification within sixty (60) days will result in the loss of continuation coverage rights. A Qualified Beneficiary's failure to notify the Plan Sponsor of a qualifying event within sixty (60) days of the event may result in retroactive cancellation of the Covered Employee's/ Dependent's continuation coverage, and the Plan may seek reimbursement from the Employee/Dependent for any benefits paid after the qualifying event.

The Covered Employee and each eligible Dependent must elect COBRA continuation coverage within sixty (60) days of the date that coverage would end or, if later, within sixty (60) days of the date that their employer first sent notice of the right to elect COBRA continuation coverage.

The Plan Sponsor has the responsibility of notifying the Plan of a Covered Employee's death, termination of employment, reduction in hours, entitlement to Medicare or the Employer's bankruptcy within 30 days of the qualifying event.

The Plan will notify Covered Employees or the qualifying individual of continuation coverage rights within fourteen (14) days of the notice described above. Each qualifying individual will then have sixty (60) days to elect continuation coverage. Failure to elect

continuation coverage within sixty (60) days after notification of the qualifying individual will result in loss of continuation coverage rights.

Termination of Coverage

Under federal law and under this Plan, COBRA continuation coverage will end on the first of the following dates:

- The date the Plan Sponsor terminates all group health plans.
- The date a required premium or contribution is due and not paid on time.
- The date a Qualified Beneficiary becomes covered by another group plan without an enforceable pre-existing condition exclusion or limitation.
- The date a Qualified Beneficiary becomes entitled to Medicare.
- The date the applicable period of continuation coverage is exhausted.
- The first day of the month that begins more than thirty-one (31) days after the date that the Qualified Beneficiary is no longer disabled, in situations where coverage was extended for eleven (11) months, as long as the period of COBRA continuation coverage does not exceed twenty-nine (29) months.
- Special continuation periods apply to Retirees and their Dependents if the Plan Sponsor declares bankruptcy under Title 11 of the United States Code, and the Retirees and their Dependents lose substantial coverage within one year before or after the date that the bankruptcy proceedings commenced. Retirees may continue their coverage until their death. For a spouse, surviving spouse, or dependent child of the Retiree, coverage will end at the earlier of the Qualified Beneficiary's death or thirty-six (36) months past the date of the death of the Retiree.

Cost of Continuation Coverage

Except as a higher amount is allowed in accordance with this section, the Plan may require all Qualified Beneficiaries to pay a premium for continuation coverage of up to one hundred two percent (102%) of the Plan's cost for a "similarly situated" eligible covered individual.

Continuation of Coverage Under the Trade Act of 1974

Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a 'trade readjustment allowance' or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family Covered Persons (if they did not already elect COBRA coverage), but only within a limited period of sixty (60) days (or less) and only during the six months immediately after their group health plan coverage ended. If you qualify or may qualify for assistance under the Trade Act of 1974, contact the Plan Sponsor for additional information. You must contact the Plan Sponsor promptly after qualifying for assistance under the Trade Act of 1974, or you will lose your special COBRA rights.

Continuation of Coverage Under the Family and Medical Leave Act of 1993 (FMLA)

The FMLA requires the Plan Sponsor to provide eligible employees with up to twelve (12) weeks per year of unpaid leave in the case of the birth, adoption or foster care of an employee's child or for the employee to care for his/her own sickness or to care for a seriously ill child, spouse, or parent. In compliance with the provisions of the FMLA, the Plan Sponsor is required to maintain a Covered Employee's prior coverage under the Plan during his/her period of leave under the FMLA just as if the Covered Employee were Actively Employed. The Covered Employee's and his/her Dependents' coverage under the FMLA will cease once the Plan is notified or otherwise determines that the Covered Employee has terminated employment, exhausted his/her twelve (12) week FMLA leave entitlement, or does not intend to return from leave.

Once the Plan or the Plan Sponsor is notified or otherwise determines that a Covered Employee is not returning to employment following a period of FMLA leave, the Covered Employee may elect to continue his/her coverage under the COBRA continuation rules, as described above in this Section. The qualifying event entitling the Covered Employee and qualified Dependents to COBRA continuation coverage is the last day of the Covered Employee's FMLA leave.

If the Covered Employee fails to return to Active Employment with the Plan Sponsor following his/her FMLA leave, the Plan may recover the value of any benefits it paid on behalf of the Covered Employee and his/her Dependents during the period of FMLA leave, unless the Covered Employee's failure to return was based upon the continuation, recurrence, or onset of a serious health condition which would otherwise qualify the Covered Employee for leave under the FMLA. If the Covered Employee fails to return from FMLA for impermissible reasons, the Plan may offset payment of any medical claims that that the Covered Employee and his/her Dependents incurred prior to the period of FMLA leave but that have not yet been paid against the value of benefits paid on the Covered Employee's or his/her Dependents' behalf during the period of FMLA leave.

Continuation of Coverage Under the Uniformed Services Employment & Re-employment Rights Act of 1994 (USERRA)

USERRA requires that the Plan provide Covered Employees the right to elect continuous health coverage for the Covered Employees and their eligible Dependents for up to eighteen (18) months, beginning on the date the Covered Employee's absence begins from employment due to military service, including Reserve and National Guard Duty, as described below.

If a Covered Employee is absent from employment by reason of service in the uniformed services, he/she can elect to continue coverage for himself/herself and his/her eligible Dependent under the provisions of USERRA. The period of coverage for the Covered Employee and his/her eligible Dependents ends on the earlier of:

- The end of the eighteen (18) month period beginning on the date on which the Covered Employee's absence begins; or

- The day after the date on which the Covered Employee is required, but fails to apply for, or return to, a position of employment for which coverage under this Plan would be extended (for example, for periods of military services over one hundred eighty (180) days, generally the Covered Employee must re-apply for employment within ninety (90) days of discharge).

  A Covered Employee may be required to pay a portion of the cost of his/her benefits. If your military service is less than thirty-one (31) days, you will be required to pay no more than your share of the premium for this period of coverage. Beyond thirty-one (31) days, you must pay the cost of the coverage. Such cost will not exceed one hundred two percent (102%) of the cost of your coverage, similar to the manner in which premiums for COBRA continuation coverage are calculated.

  A Covered Employee must notify the Plan Sponsor that he/she will be absent from employment due to military service unless the Covered Employee cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable. A Covered Employee must also notify the Plan Sponsor that he/she wishes to elect continuation coverage for himself/herself or his/her eligible Dependents under the provisions of USERRA.

INQUIRIES AND APPEALS

Informal Inquiry Process

Most Appeals begin as an informal inquiry. Covered Persons should direct informal inquiries to the Plan via the Claims Administrator Customer Service Department Monday through Friday from 8:00 a.m. to 6:00 p.m. C.S.T. at the following telephone numbers: (866) 557-8751 or (217) 366-1226.

A Customer Service Associate will review, research and resolve the inquiry. The Covered Person will be informed of the resolution within thirty (30) days. At the time of resolution, if the decision is adverse to the Covered Person, the Covered Person will be advised of his/her right to request a formal Appeal. Covered Persons also have the right to bypass the informal inquiry procedures and immediately file a formal Appeal.

Appeal Process

An Appeal is a request by a Covered Person or Covered Person's Authorized Representative for reconsideration of an Adverse Benefit Determination of a health service request or a benefit that the Covered Person believes he or she is entitled to receive. There are two different types of Appeals:

- **Healthcare Service Appeals**. A health care service appeal is an Appeal to change a previous decision made by the Health Plan where the denial has been issued for Medical Necessity or medical appropriateness or which relates to a medical decision.
- **Administrative Appeals**. An administrative appeal involves non-healthcare related issues, such as coverage issues, which are administrative in nature.

There are also three different categories of Appeals:

- **Pre-Service Appeals.** Pre-service appeals are those appeals for which a requested service requires Prior Authorization, an Adverse Benefit Determination has been rendered, and the requested service has not been provided.
- **Post-Service Appeals.** Post-service appeals are those appeals for which an Adverse Benefit Determination has been rendered for a service that has already been provided.
- **Urgent Care Appeals.** An urgent care appeal is an appeal that must be reviewed under an expedited appeal process because the application of non-urgent care appeal time frames could seriously jeopardize: (a) the life or health of the Covered Person; or (b) the Covered Person's ability to regain maximum function. In determining whether an appeal is an urgent care appeal, the Health Plan will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. An urgent care appeal is also an appeal involving: (a) care that the treating physician deems urgent in nature; or (b) the treating physician determines that a delay in the care would subject the Covered

Person to severe pain that could not be adequately managed without the care or treatment that is being requested.

Throughout the procedures outlined in this Section, if the Covered Person or Authorized Representative fails to file any Appeal within the required timeframes, the Covered Person loses the right to continue the internal appeal process. Covered Persons have the right, but are not required to, appear in person or to be represented by an attorney during any stage of the inquiry or Appeal procedure. In each step of the inquiry and Appeal procedure, Covered Persons should be as specific as possible as to the remedy sought (e.g., claim denied – remedy sought is payment).

Pre-Service and Post-Service Appeals

If you are dissatisfied with an Adverse Benefit Determination and wish to file a pre-service or post-service appeal with the Plan, you have the right to request such an appeal. Your or your Authorized Representative has one hundred eighty (180) days after the Covered Person's receipt of the initial notice of Adverse Benefit Determination to file an Appeal with the Plan. Requests received after such one hundred eighty (180) day period will not be eligible for the internal Appeal process.

In order to request a pre-service or post-service appeal from the Plan, you or your Authorized Representative must submit a written request to the Claims Administrator at the address above, Attention: Member Appeals and include the following:

- Your name;
- Provider name;
- Date(s) of service;
- Your mailing address and/or the mailing address of your Authorized Representative;
- Clear indication of the remedy or corrective action being sought and an explanation of why the Health Plan should reverse the Adverse Benefit Determination; and
- Copy of documentation to support the reversal of the decision.

You or your Authorized Representative may also include written comments, documents, records and other information relevant to the appeal. The Plan will notify you or your Authorized Representative within three (3) business days from receipt of the appeal of any additional information it will need to evaluate your appeal.

Your appeal will be investigated and reviewed by the Plan. For both administrative and healthcare service appeals, your appeal will be reviewed by individuals who were not involved in any previous reviews and are not the subordinate of an individual who made any prior Adverse Benefit Determination. For health care service appeals based in whole or in part upon a medical judgment, your appeal will be handled in consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

The Plan will notify you or your Authorized Representative in writing of the decision on appeal within fifteen (15) business days after receipt of all required information but no later than thirty (30) calendar days (pre-service) or sixty (60) calendar days (post-service) from receipt of your initial appeal request. The notice will contain all information as required by applicable state and federal laws and regulations. In addition, you have the right to receive, upon request and free of charge, reasonable access to and/or copies of all documents, records and other information relevant to your appeal.

Urgent Care Appeals

If you have an appeal which meets the definition of an urgent care appeal as set forth above, you or your Authorized Representative may request an expedited appeal. Such an appeal can be requested in writing, or orally, by contacting the Claims Administrator's Customer Service Department at (866) 557-8751 at any time. The request can also be made by a provider acting as your Authorized Representative.

If the appeal constitutes an urgent care appeal, we will call you or your Authorized Representative within twenty-four (24) hours from receipt of the appeal to provide notice of any additional information we will need to evaluate your appeal. Your urgent care appeal will be investigated and reviewed by the Plan. Your appeal will be reviewed by individuals who were not involved in any previous reviews and are not the subordinate of an individual who made any prior adverse benefit determination. For health care service appeals based in whole or in part upon a medical judgment, your urgent care appeal will be handled in consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

The Plan will notify you or your Authorized Representative of its decision on appeal as expeditiously as possible but not later than seventy-two (72) hours from receipt of your initial urgent care appeal request. If the initial decision is not conveyed to you orally, we will provide written confirmation to you within three calendar days thereafter. The notice will contain all information as required by applicable state and federal laws and regulations.

Other Appeal Rights

As a Covered Person or beneficiary of an employee welfare benefit plan under ERISA, Covered Persons may have the right to bring a civil action under ERISA Section 502(a). Covered Persons may exercise this right to recover Covered Services due under the Plan, enforce the Covered Person's rights under the Plan, or to clarify rights to future Covered Services under the terms of the Plan. Covered Persons must exhaust the internal Appeal process before bringing a civil action under ERISA Section 502(a).

HIPAA PRIVACY

In fulfillment of the requirements of Section 504(f)(2) of the privacy rule found in 45 C.F.R. Part 164 (the "Privacy Rule") promulgated pursuant to the federal Health Insurance Portability and Accountability Portability Act of 1996, Public Law 104-191 ("HIPAA"), the Plan provides as follows:

Consistent with the HIPAA Privacy Rule, persons holding positions with the Plan Sponsor or its affiliates and who have access to individually identifiable health information deemed "protected health information" ("PHI") under the Privacy Rule are identified below, and are restricted to using and disclosing PHI for Plan administrative purposes such as those described as "payment" and "health care operations" under the Privacy Rule. More particularly, such uses and disclosures may include: evaluating the Plan's claims experience; seeking proposals for insurance or reinsurance of Plan benefits; reporting to stop-loss carriers; administering case, quality and utilization management programs; determining the application of Plan provisions to particular claims; and assisting Covered Persons and beneficiaries with the filing of claims.

The classes of positions within the workforce of the Plan Sponsor that may receive, use or disclose PHI for the purposes set forth in Section are:

- City Clerk's Office Personnel (who are responsible for Human Resource functions, including Benefits Administration and Risk Management)
- Finance Department Personnel
- City Attorney & Treasurer
- City Administrator
- Commissioner of Finance

Employees in the job functions described above will have access to Plan Covered Persons' PHI only for the purposes described above (i.e., administrative functions performed for the Plan).

Covered Persons or beneficiaries of the Plan with knowledge that:

employees of the Plan Sponsor, other than employees in the positions identified in this Section, have used or disclosed Plan PHI;

employees in the positions identified in this Section have used or disclosed the PHI outside the scope of Plan administration; or

employees of the Plan Sponsor have acted contrary to the Plan Sponsor covenants described below,

may report such non-conforming activity to Susan O'Brien, City Clerk, who is the Plan's privacy contact person and who will work with appropriate Plan and Plan Sponsor personnel to correct the breach or deficiency, mitigate the effect of the breach or deficiency, and impose appropriate disciplinary sanctions.

The Plan will not disclose PHI to employees of the Plan Sponsor for the administrative purposes described herein without obtaining a certification (the "Certification") from the Plan Sponsor to the effect that the Plan Sponsor will:

- not use or further disclose individually identifiable health information created in connection with the Plan except as required by law or for Plan administrative purposes as described above, as such administrative purposes may be amended from time to time;

- arrange for any agents or subcontractors of the Plan Sponsor that receive PHI to use and disclose PHI consistent with the Certification;

- not use or disclose the PHI for employment related actions or in connection with any other benefits or benefit plans;

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

- make available to the Plan any PHI in any "designated record set" (as such term is defined in the Privacy Rule) related to Plan Covered Persons or beneficiaries that the Plan Sponsor has control of in accordance with the access requirements of the Privacy Rule;

- make available for amendment, to the extent required by the Privacy Rule, the PHI in a designated record set which is related to Plan Covered Persons or beneficiaries and incorporate any amendment as required by the Privacy Rule;

- make information available to the Plan for, or provide the Plan with, an accounting of PHI disclosures (to the extent required by the Privacy Rule, e.g., other than for treatment, payment, health care operations or other exempt purposes) related to Plan Covered Persons or beneficiaries in response to such person's exercise of his/her rights under such section;

- 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 to assist the Secretary in determining the Plan's compliance with the Privacy Rule;

- where feasible, return to the Plan or destroy any PHI received from the Plan when such PHI is no longer needed by the Plan Sponsor for the purpose which permitted the Plan to make the disclosure and, where such return or destruction of PHI is not feasible, to limit its future use of the PHI to the situations that make the return or destruction of the PHI not feasible; and

- limit access of its employees to the Plan's PHI (other than as subjects of the PHI or subscribers to the payment), except where such employees are in job classifications which have been designated above as assisting in Plan administration and thus

engaging in the use or disclosure of PHI for treatment, payment and health care operations purposes.

MISCELLANEOUS

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the City of Mattoon to the effect that you will be employed for any specific period of time.

Applicability

The provisions of this document shall apply equally to the Covered Employee and Dependents and all benefits and privileges made available to Covered Employee shall be available to Covered Employee's Dependents.

Exhaustion of Administrative Remedies

Covered Person may not bring a cause of action hereunder in a court or other governmental tribunal unless and until all administrative remedies set forth in this document have first been exhausted.

Nontransferable

No person other than Covered Person is entitled to receive health care service coverage or other benefits to be furnished by Plan. Such right to health care service coverage or other benefits is not transferable.

Relationship Among Parties

The relationship between Claims Administrator and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of Claims Administrator, nor is Claims Administrator or any employee of Claims Administrator an employee or agent of Participating Providers. Participating Providers shall maintain the provider-patient relationship with Covered Person and are solely responsible to Covered Person for all Participating Provider services.

Neither the Plan Sponsor nor Covered Person is an agent or representative of Claims Administrator, and neither shall be liable for any acts or omissions of Claims Administrator for the performance of services under this document.

Reservations and Alternatives

Plan and Claims Administrator reserve the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein.

Severability

In the event that any provision of this document is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this document, which shall continue in full force and effect in accordance with its remaining terms.

Waiver

The failure of Claims Administrator, the Plan Sponsor, or Covered Person to enforce any provision of this document shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this document shall not be deemed or construed to be a waiver of such default.

DEFINITIONS OF TERMS

The terms are capitalized to highlight their use.

ACCIDENT - Means an injury which is:
1. Caused by an event which is sudden and unforeseen; and
2. Exact as to time and place of occurrence.

ADVERSE BENEFIT DETERMINATION – Means a denial of a request for service or failure to provide or make payment (in whole or part) for a Covered Service. Adverse Benefit Determination also includes any reduction or termination of a Covered Service.

ALCOHOL, CHEMICAL DEPENDENCY OR DRUG ADDICTION TREATMENT FACILITY - Means a facility (other than a hospital) whose primary function is the treatment of alcoholism, chemical dependency or drug addiction and which is approved by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) or is duly licensed by the appropriate governmental authority to provide such services.

AMBULANCE - Emergency transportation in a specially equipped certified vehicle from the Covered Person's home, the scene of an accident or a medical emergency to a hospital, between hospitals, between a hospital and an extended care facility or from a hospital or an extended care facility to the Covered Person's home.

AMBULATORY SURGICAL CENTER - A private or public establishment with an organized medical staff of physicians with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures with continuous physician services and registered professional nursing services. Such services must be provided whenever a patient is in the facility and such facility must not provide services or other accommodations for patients to stay overnight

APPEAL - A request by a Covered Person or the Covered Person's Authorized Representative for consideration of an Adverse Benefit Determination.

APPLICABLE PREMIUM - Means the cost to the Plan for the continuation coverage, calculated in accordance with Section 604 of ERISA.

ASSIGNMENT OF BENEFITS - Assignment of Benefits occurs when the Covered Person files a claim and authorizes the Plan to pay the Physician or Hospital directly.

AUTHORIZATION/PRIOR AUTHORIZATION - Plan has given approval for payment for certain services to be performed and an Authorization Number has been assigned. Upon Authorization, all inpatient Hospital stays are then subject to concurrent review criteria established by the Plan. Authorization does not guarantee payment if Covered Person is not eligible for Covered Services at the time the service is provided.

AUTHORIZED REPRESENTATIVE - An individual authorized by the Covered Person or state law to act on the Covered Person's behalf to submit appeals and file claims. A Provider may act on behalf of a Covered Person with the Covered Person's express consent, or without the Covered Person's express consent in an urgent care situation**.**

BENEFICIARY - The person named to receive the Covered Person's Life Insurance Benefit and/or Accidental Death Benefit. Or any person or persons (including but not limited to, an individual, trust, estate, executor, administrator or fiduciary, whether corporate or otherwise) designated to receive benefits pursuant to the terms of the Plan or any insurance policies, contracts or administrative service agreements, constituting the Plan.

BIRTHING CENTER - Means a specialized facility or a facility affiliated with a hospital which:
1. Provides twenty-four (24) hour a day nursing service by or under the supervision of registered graduate nurses (R.N.) and certified nurse midwives; and
2. Is staffed, equipped and operated to provide:
    a. Care for patients during uncomplicated pregnancy, delivery, and the immediate postpartum period;
    b. Care for infants born in the center who are normal or have abnormalities which do not impair function or threaten life; and
    c. Care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life pending transfer to a hospital.

CALENDAR YEAR - For the purposes of this Plan, a length of time beginning on January 1 and ending on December 31.

CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) – Means a person who:
1. Is a graduate of an approved school of nursing and is duly licensed as a registered nurse;
2. Is a graduate of an approved program of nurse anesthesia accredited by the Council of Certification of Nurse Anesthetists or its predecessors;
3. Has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and
4. Is recertified every two (2) years by the Council on Recertification of Nurse Anesthetists.

CHILD - The Employee's unmarried children under twenty (20) years of age. The term "Child" shall include natural children, a step-child, a foster child, a child related to the Employee by blood or marriage and for whom the Employee has assumed legal guardianship, a child whom the Employee must cover due to a Qualified Medical Child Support Order (QMCSO), subject to the conditions and limits of the law, or a legally adopted child (including the period of probation when the child is placed with the

adopting parents), in the household of such Employee. The child's placement with the Employee terminates upon the termination of the legal obligation. In all cases, other than a natural child, adopted child or a QMCSO child, the child must reside with the Employee on a permanent basis and depend mainly on the Employee for support. An unmarried child who is physically or mentally incapable of self-support upon attaining age twenty (20), may be covered under the health care benefits, while remaining incapacitated and unmarried, subject to the covered employee's own coverage continuing in effect. Such child will be considered a Covered Dependent if he was disabled either prior to his twentieth (20th) birthday or was a full-time registered student on the date he became incapacitated. To continue Covered Dependent status of a child under this provision, proof of incapacity must be received by the City within thirty-one (31) days after coverage would otherwise terminate. Additional proof will be required from time to time. Evidence satisfactory to the City of dependent eligibility under the Plan may be requested; for example, birth records or Federal Income Tax returns.

CITY – Means **City of Mattoon**, Coles County, Illinois, a municipal corporation.

CLAIMS ADMINISTRATOR - Means PersonalCare Insurance of Illinois, Inc.

COBRA - The Consolidated Omnibus Budget Reconciliation Act of 1985.

CODE - Means the Internal Revenue Code of 1986, as amended from time to time, and the regulations thereunder.

CO-INSURANCE - Means that portion of Covered Medical 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 deductible, which are to be paid by the Employee. Applicable Coinsurance amounts are set forth in the Schedule of Benefits.

CONTINUATION PREMIUM - Means the amount charged by the Plan to a Qualified Beneficiary for a specified period of continuation coverage under the Plan.

COORDINATION OF BENEFITS - If an individual is covered by another group plan of health care, this Plan will coordinate its payment of benefits with the other plan to allow as complete a claim reimbursement as possible without providing duplicate payments.

CO-PAYMENT - Means that portion of Covered Medical Expenses which must be paid by or on behalf of the Covered Person incurring the expense. Applicable Co-payment amounts are set forth in the Schedule of Benefits.

COSMETIC SURGERY - Means surgery that is intended to improve the appearance of a patient or preserve or restore a pleasing appearance. It does not mean surgery that is intended to correct normal functions of the body. This does not include reconstructive surgery resulting from an Illness or Injury.

COVENTRY TRANSPLANT NETWORK – Means a Provider designated by the Claims Administrator to provide transplant services and treatment to Covered Persons.

COVERAGE OR COVERED - The entitlement by a Covered Person to Covered Services under the Plan subject to the terms, conditions, limitations and exclusions contained in this document and the Schedule of Benefits, including the following conditions: (a) health services must be provided prior to the date that any of the termination conditions listed under this document occur; and (b) health services must be provided only when the recipient is a Covered Person and meets all eligibility requirements specified in this document; and (c) health services must be Medically Necessary.

COVERED EMPLOYEE - Means an Employee who has satisfied all applicable Eligibility provisions of the Plan and for whom coverage has not terminated.

COVERED PERSON - Means a Covered Employee or Covered Dependent as herein described.

COVERED SERVICE – Means the services or supplies provided to Covered Person for which Plan Sponsor will make payment, as described in the document.

CUSTODIAL CARE - Means care consisting of services and supplies provided to a Covered Person, in or out of an institution, primarily to assist him in daily living activities, whether he is or is not disabled.

DEDUCTIBLE - The amount of Covered Medical Expenses that a Covered Person must pay before he can receive a benefit payment under the Medical Benefits. Applicable Deductible amounts are set forth in the Schedule of Benefits.

DEPENDENT - For the purposes of this Plan, the Employee's spouse and children to the age of twenty (20), (see definition of "Child"), full-time students (see definition of "Student"), and disabled children, if such incapacity occurred prior to the limiting age specified.

DIALYSIS FACILITY - Means a facility (other than a Hospital) whose primary function is the provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

DISABLED -
1. The Covered Person's complete inability as an active employee, to perform any and every duty pertaining to his occupation or employment or for any occupation for wage or profit, or
2. The Covered Dependent's complete inability to perform the normal activities of a person of like age and sex, or

3. The Covered Person's complete inability, as a retired employee, to perform the normal activities of a person of like age and sex.

DURABLE MEDICAL EQUIPMENT - Only that equipment and those supplies that:
1. Are primarily and customarily used to serve a medical purpose;
2. Would not be generally useful to a person in the absence of an Illness or Injury;
3. Are designed for repeated use; and
4. Either:
    a. Are Medically Necessary to:
        i. Treat an Illness or Injury;
        ii. Effect improvement of a Covered Person's medical condition; or
        iii. Arrest or retard deterioration of a Covered Person's medical condition; or
    b. Are alternatives to chair or bed confinement.

ELECTED OFFICIAL - For the purposes of this Plan, Elected Officials will be considered Employees of the Plan. The Mayor and City Commissioners who hold elected positions within the City Of Mattoon are eligible for coverage under this Plan.

ELECTIVE SURGERY - Means surgery that is not emergency in nature or is not performed to correct a life-threatening situation.

EMERGENCY MEDICAL CONDITION - A condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES - Transportation services, including, but not limited to, ambulance services, and Covered inpatient and outpatient hospital services furnished by a Provider qualified to furnish those services that are needed to evaluate or stabilize an Emergency Medical Condition. It does not mean post-stabilization medical services.

EMPLOYEE - An Employee who is directly employed in the regular business of and compensated for services by the City and regularly works full-time. Elected officials and Retirees, as defined, are eligible for coverage under this Plan.

ENROLLMENT FORM – Means the application for enrollment in the Plan.

ERISA - Means the Employee Retirement Income Security Act of 1974, as amended. As a Covered Person of the Plan, the Covered Person has a number of rights under ERISA as outlined.

EXPERIMENTAL OR INVESTIGATIONAL - A health product or service is deemed experimental or investigational if one or more of the following conditions are met:

(i) Any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA; any drug requiring Prior Authorization that is proposed for off-label prescribing;

(ii) Any health product or service that is subject to Investigational Review Board (IRB) review or approval;

(iii) Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations;

(iv) Any health product or service that is considered not to have demonstrated value based on clinical evidence reported by Peer-Review Medical Literature and by generally recognized academic experts.

Note: Although a physician may have prescribed treatment, such treatment may still be considered Experimental by the Plan Administrator in its sole discretion within the context of this definition.

EXTENDED CARE FACILITY (CONVALESCENT FACILITY) -Means

1. It is a Skilled Nursing Facility, as the term is defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare, except for a Skilled Nursing Facility which is part of a hospital, as defined, or;

2. It is an institution, which fully meets all of the following tests:

a. It is operated in accordance with the applicable laws of the appropriate governmental authority where it is located.

b. It is under the supervision of a licensed Physician, or Registered Nurse (R.N.) , who is devoting full-time to such supervision.

c. It is regularly engaged in providing room and board and continuously provides twenty-four (24) hour-a-day skilled nursing care of ill and injured persons at the patient's expense during the convalescent stage of an injury or illness.

d. It maintains a daily medical record of each patient who is under the care of a duly licensed Physician.

e. It is authorized to administer medication on the order of a duly licensed Physician.

f. It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

g. It is not a hospital, as defined, or part of a hospital.

GENERIC DRUGS - Means prescription drugs and prescription medicines, which are not protected by a trademark.

GROUP HEALTH PLAN - Means any plan or arrangement constituting a group health plan under Section 607(l) of ERISA.

HEALTH BENEFITS - Means benefits provided under a Group Health Plan for medical care as defined pursuant to Section 213(d) of the Code.

HOME HEALTH AIDE - Means a person who provides care of a medical or therapeutic nature and reports to and is under the direct supervision of a Home Health Care Agency.

HOME HEALTH CARE AGENCY - Is either:
1. An Agency that is certified to participate as a Home Health Care Agency under Medicare;
2. A hospital that has a valid operating certificate and is certified by the appropriate authority to provide home health services;
3. An agency licensed as such, if such licensing is required, in the state in which such Home Health Care is delivered; or
4. A public agency or private organization or subdivision of such that meets the following requirements:
    a. It is primarily engaged in providing nursing and other therapeutic services;
    b. It is duly licensed, if such licensing is required, by the appropriate licensing authority, to provide such services;
    c. It is federally certified as a Home Health Care Agency.

HOME HEALTH CARE PLAN - Means a Home Health Care program, prescribed in writing by a person's Physician, for the care and treatment of the person's Illness or Injury in the person's home. In the Plan, the Physician must certify that an inpatient stay in a Hospital, a Convalescent Nursing Home, or an Extended Care Facility would be required in the absence of the services and supplies provided as part of the Home Health Care Plan. The Home Health Care Plan must be established in writing no later than fourteen (14) days after the start of the Home Health Care. An inpatient stay is one for which a room and board charge is made.

HOSPICE CARE -
1. Means a coordinated, interdisciplinary Hospice-provided program meeting the physical, psychological, spiritual and social needs of dying individuals, and
2. Consists of palliative and supportive medical, nursing and other health services provided through home or inpatient care during the illness to a Covered Person who has no reasonable prospect of cure and as estimated by a Physician, has a life expectancy of fewer than six (6) months; and consists of bereavement counseling for members of such Covered Person's immediate family.

HOSPICE CARE FACILITY - Is either:
1. A free-standing facility which is fully staffed and equipped to provide for the needs of the terminally ill (and their families); or
2. An inpatient facility which is part of a hospital but designated as a Hospice unit or is an adjacent facility, administered by a Hospital and designated as a Hospice unit. A Hospice Care Facility must be approved by the Joint Commission on Accreditation of

Healthcare Organizations (JCAHO) or must meet the standards of the National Hospice Organization (NHO) and the appropriate licensing authority, if such licensing is required.

HOSPICE TEAM - A team of professionals and volunteer workers who provide care to reduce or abate pain or other symptoms of mental or physical distress. Such team should serve the special needs arising out of the stress of the terminal illness, dying and bereavement. The team may include a physician, registered social worker, clergyman/counselor, volunteers, clinical psychologist, physiotherapist and/or occupational therapist.

HOSPITAL - A legally operated institution which meets either of these tests:
1. Is accredited as a Hospital under the Hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or
2. Is a Hospital, as defined, by Medicare, which is qualified to participate and eligible to receive payments under an in accordance with the provisions of Medicare, or
3. Is supervised by a staff of physicians, has twenty-four (24) hour-a-day nursing services, and is primarily engaged in providing either:

a. General inpatient medical care and treatment through medical, diagnostic and major surgical facilities on its premises or under its control, or
b. Specialized inpatient medical care and treatment through medical and diagnostic facilities (including x-ray and laboratory) on its premises, or under its control, or through a written agreement with a Hospital (which itself qualifies under this definition) or with a specialized provider of these facilities.
c. A psychiatric Hospital primarily engaged in diagnosing and treating mental illness, if it meets all of the requirements set forth in clause (a) other than the major surgery requirement.
d. A free standing treatment facility, other than a Hospital, whose primary function is the treatment of alcoholism or drug abuse provided the facility is duly licensed by the appropriate governmental authority to provide such service, and is accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Hospital Association.
e. A rehabilitative Hospital, which is an institution operated primarily for the purpose of providing the specialized care and treatment for which it is duly licensed, and which meets all of the requirements of an accredited Hospital.

In no event will the term "Hospital" include a nursing home or an institution or part of one which:

a. Is primarily a facility for convalescence, nursing, rest, or the aged, or
b. Furnishes primarily domiciliary or custodial care, including training in daily living routines, or
c. Is operated primarily as a school.

ILLNESS - A bodily disorder, disease, pregnancy, or mental infirmity. All bodily injuries sustained by an individual in a single accident or all illnesses, which are due to the same or related cause or causes, will be deemed one illness.

INCURRED EXPENSE - Means a charge which the Covered Person is legally obligated to pay and shall be deemed to be incurred on the date the purchase is made or on the date the service is rendered for which the charge is made. Anticipated expenses are not incurred expenses.

INJURY - An unforeseen happening to the body requiring medical attention and includes all related symptoms and recurrent conditions resulting from the accident, not including intentional, self-inflicted injuries.

INPATIENT - A person receiving room and board while undergoing treatment in a Hospital, Hospice or other covered facility.

INTENSIVE CARE UNIT - Means a section, ward or wing within a hospital which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by professional nurses or other highly trained personnel, excluding any hospital facility maintained for the purposes of providing normal post-operative recovery treatment or services.

LEAVE OF ABSENCE - Means a period of time during which the employee does not work but which is of stated duration after which time the employee is expected to return to active full-time work.

LICENSED PRACTICAL NURSE/LICENSED VOCATIONAL NURSE - Means an individual who has received specialized nursing training and practical nursing experience and who is licensed to perform such service, other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

LIFETIME - When used 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 DIRECTOR - The Physician specified by Plan Administrator or Claims Administrator as the Medical Director or other staff designated to act for, under the general guidance of, and in consultation with the Medical Director.

MEDICAL EXPENSE BENEFIT - After satisfaction of the applicable deductible, benefits will be provided for covered medical expenses for an illness or injury in a calendar year.

MEDICALLY NECESSARY/MEDICAL NECESSITY - Those services, supplies, equipment and facilities charges that: are not expressly excluded under the Plan and determined by the Plan, in its sole discretion to be:

(i) Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks*;*

(ii) Necessary to meet health needs of the Covered Person, improve physiological function and required for a reason other than improving appearance;

(iii) Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;

(iv) Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which coverage is requested;

(v) Consistent with the diagnosis of the condition at issue;

(vi) Required for reasons other than comfort or the comfort and convenience of the Covered Person or his or her Physician; and

(vi) Not Experimental or Investigational as determined by the Plan under our Experimental Procedures Determination Policy. (A copy of the Experimental Procedures Determination Policy is available upon request from the Claims Administrator's Member Services Department.)

(vii) For hospitalizations, "medically necessary" means that acute care as an inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's medical condition, and that safe and adequate medical care cannot be received as an outpatient or in a less intensified medical setting.

Note: The fact that the service is prescribed, ordered, recommended or approved by a physician does not, of itself, mean the service is "medically necessary". In an effort to make treatment convenient, to follow the wishes of the patient or the patient's family, to investigate the use of unproven treatment methods, or to comply with local Hospital practices, a physician may suggest or permit a method of providing care that is not "medically necessary".

MEDICARE - Means Title XVIII of the Social Security Act of 1965, as amended from time to time, and the regulations thereunder.

NON-PARTICIPATING PROVIDER - A Provider who has no direct or indirect written agreement with the Claims Administrator to provide health services to Participants.

NOTICE OF BENEFIT DETERMINATION - A notice of approval, denial, reduction or termination of benefits, or the failure to provide or pay for benefits.

OCCUPATIONAL THERAPY – Means treatment rendered as a part of a physical medicine and rehabilitation program to improve functional impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. Benefits are not provided for diversion, recreational and vocational therapies (such as hobbies, arts & crafts).

ORTHOTIC APPLIANCE – Means an external device intended to correct any defect in form or function of the human body.

OUT-OF-NETWORK COVERAGE OPTION - Covered Services provided to Covered Persons by a Non-Participating Provider. These Covered Services may still require Prior Authorization.

OUT-OF-NETWORK RATE - The amount the Plan pays for Covered Services rendered by a Non-Participating Provider under the Out-of-Network Coverage Option.

OUT-OF-POCKET MAXIMUM - Means the maximum covered expense, in excess of the Deductible, that a Covered Person or family must pay before the Plan pays 100% of the balance of eligible medical expenses for such person or family for the remainder of the Calendar Year.

OUTPATIENT – Means when a Covered Person receives diagnosis, treatment or twenty-three (23) hour observation in a hospital or treatment facility but is not admitted as an inpatient.

COVERED PERSON - Means Any Covered Employee or Dependent or Qualified Beneficiary (as that term is defined under COBRA) who enrolled for coverage under this Plan in accordance with its terms and conditions.

COVERED PERSON EFFECTIVE DATE - The date entered on Plan records as the date when coverage for a Covered Person under the Plan begins in accordance with the terms of this document, which coverage shall begin at 12:01 a.m. on such date.

PARTICIPATING PROVIDER - A Provider who has entered into a direct or indirect written agreement with the Claims Administrator to provide health services to Covered Persons. "Participating" refers only to those Providers included in the network of Providers described in the Provider Directory of Health Care Providers automatically delivered to Covered Persons, without charge, in connection the Plan. The participation status of Providers may change from time to time.

PHARMACY - Means any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPY – Means treatment by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound, manipulation and subluxation; as well as tests of measurement requirements to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following illness, injury or loss of body parts. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or other professional are required.

PHYSICIAN - Means a medical doctor (M.D.), an osteopath (D.O.), a dentist or dental surgeon (D.D.S., D.M.D.), a podiatrist (D.P.M.), a chiropractor (D.C.), an optometrist (D.O.), a midwife, a clinical or child psychologist, holding a doctor of philosophy degree (Ph.D.); a clinical or child psychologist holding a master's degree (M.A. or M.S.); or masters in social work (M.S.W.) or licensed professional counselor (when licensing is required by the state in which the counselor resides), and whose work is supervised directly by either a psychiatrist (M.D.) or clinical psychologist (Ph.D.) A Physician may also include other licensed practitioners operating within the legal scope of the license to the extent they, within the scope of their license are permitted to perform the services provided by this Plan. A Physician shall not include the Covered Person or any close relative of the Covered Person.

PLAN - Means the **City of Mattoon's** Employee Health Care Plan.

PLAN ADMINISTRATOR/SPONSOR – Means the **City of Mattoon**, the entity responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other services related to the Plan.

PLAN DOCUMENT - The legal document according to which the Plan is administered and governed.

PLAN YEAR - The period during which the total amount of yearly benefits is calculated. The plan year is the period of twelve (12) consecutive months commencing January 1st and each subsequent anniversary.

POST-SERVICE APPEAL - An Appeal regarding an Adverse Benefit Determination for a Post-Service Claim.

POST-SERVICE CLAIM - A claim for payment for or reimbursement cost of medical care that the Covered Person has already received.

PRE-ADMISSION TESTING - Means x-rays, laboratory examinations or other tests performed in the outpatient department of a hospital or other facility prior to outpatient treatment or to confinement as an inpatient provided:
1. Such tests are related to the scheduled hospital confinement;
2. Such tests have been ordered by a duly qualified physician after a condition requiring such confinement has been diagnosed and hospital admission has been requested by the physician, approved by the Utilization Review Service, and confirmed by the hospital; and
3. The Covered Person is subsequently admitted to the hospital, or the confinement is canceled or postponed because a hospital bed is unavailable, or under the directions of the attending physician, or because there is a change in the patient's condition which precludes the confinement.

PREGNANCY – Means that physical state which results in childbirth, abortion or miscarriage, and any medical complications arising out of, or resulting from, such state.

PRE-SERVICE APPEAL - An Appeal for which a requested service requires Prior Authorization, an Adverse Benefit Determination has been rendered, and the requested service has not been provided.

PRE-SERVICE CLAIM - A request for a benefit that has not yet been received and for which Prior Authorization is required. Pre-service Claims do not include Urgent Care Claims.

PROSTHETIC DEVICE – Means a device which:
1. Replaces all or part of a missing body organ and its adjoining tissue; or
2. Replaces all or part of the function of a permanently useless or malfunctioning organ.

PROVIDER/PROVIDER NETWORK – A Physician, Hospital, skilled nursing facility, home health agency, hospice, pharmacy, podiatrist, optometrist, chiropractor or other health care institution or practitioner, licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

PSYCHIATRIC DISORDER - Neuroses, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind.

PSYCHIATRIC TREATMENT - Treatment or care for:
1. A mental or emotional disease or disorder;
2. A functional nervous disorder; or
3. Psychological effects of Substance Abuse.

QUALIFIED BENEFICIARY - means any Beneficiary who is a qualified beneficiary as defined under Section 607(3) of ERISA.

REASONABLE AND CUSTOMARY FEE LIMITATION - An amount measured and determined by comparing the actual charge with the charges customarily made for similar services and supplies to individuals of similar medical conditions in the locality concerned. The term "locality" means a county or such greater geographically significant area as is necessary to establish a representative cross section of persons, or other entities regularly furnishing the type of treatment, services or supplies for which the charge was made.

REGISTERED NURSE - Means a professional nurse who has the right to use the title Registered Nurse (R.N.) other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

RETIREE - For the purposes of this Plan, Retirees will be considered employees of the Plan. A retired employee eligible to participate in the Plan shall be a person who becomes eligible for an immediate pension under either the Illinois Municipal Retirement Fund

Pension (ILCS CH.40, Act 5, § 7-101 et seq.) or the Police Pension System (ILCS CH. 40, Act 5, § 3-101 et seq.) or the Fire Fighter Pension System (ILCS CH.40, Act 5, § 4-101 et seq.)

ROOM AND BOARD - Services regularly furnished by the Hospital as a condition of occupancy, but not including professional services.

SCHEDULE OF BENEFITS - Shall mean the Schedule of Benefits provided with this document.

SOUND NATURAL TOOTH – Means a tooth which:
1. Is free of decay, but may be restored by filings;
2. Has a live root; and
3. Does not have a cap or a crown.

SPECIALTY CARE PHYSICIAN/SPECIALIST – A Physician who provides medical services to Covered Persons within the range of a medical specialty.

SPEECH THERAPY – Means active treatment for improvement of an organic medical condition causing a speech impairment. Treatment must be either post-operative or for the convalescent stage of an illness or injury.

SPOUSE - The person who is legally married to the Employee while the Employee is covered under this Plan.

STUDENT - Means the Employee's unmarried child under twenty-four (24) years of age attending an accredited educational institution who is enrolled for at least twelve (12) hours of credit in any one (1) semester of, if the institution is not organized on a semester system, the equivalent of twelve (12) semester hours. Full-time student status will continue during semesters when the Plan receives notification that the student is registered for the following semester. **Note: When benefits are paid on behalf of the student between semesters, and if the student does not resume attendance the following semester, benefits paid during this time will be the responsibility of the Employee and there will be monies due back to the Plan. The Plan will be immediately entitled to a complete recovery in full of all such benefits paid.** Proof of student status, verified by the school, is required within thirty (30) days of the child's twentieth (20th) birthday and at the beginning of each semester.

SUBSTANCE ABUSE - An excessive use of alcohol and/or drugs that results in physiological and/or psychological dependency of such substances.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ) – Means pain, swelling, clicking, grinding, popping, dislocation, locking, malposition, bite discrepancies or other pathological conditions which create a loss or decrease of function in or around one or both of the jaw joints.

TERMINALLY ILL PATIENT - Means a person with a life expectancy of six (6) months or less as certified in writing by the attending physician.

URGENT CARE APPEAL - An Appeal that must be reviewed under the expedited Urgent Care Appeal process because the application of non-Urgent Care Appeal time-frames could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function. In determining whether an appeal should be expedited, the Plan will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. An Urgent Care Appeal is also an Appeal involving care that the treating physician deems urgent in nature, or the treating physician determines that a delay in care would subject the Covered Person to severe pain that could not be adequately managed without the care or treatment that is being requested.

URGENT CARE CLAIM - A claim for payment for medical care or treatment that meets one of the following conditions:

(i) The application of the time periods for making non-urgent care determinations could: (a) seriously jeopardize the life or health of the Covered Person, or the Covered Person's ability to regain maximum function; or (b) in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or

(ii) The Plan determines that a prudent layperson who possesses an average knowledge of health and medicine would have judged the situation to require Emergency Service; or

(iii) A Physician with knowledge of the Covered Person's medical condition determines that the claim involves Emergency Service; or

(iv) The claim occurs during the course of a treatment or Hospital stay and is subject to concurrent review, which is a review of all reasonably necessary supporting information during a Hospital stay or course of treatment as the treatment is being rendered that results in a decision by the Plan to approve or deny payment for ongoing or additional treatment.

WORKERS' COMPENSATION - A fund administered under any Workers' Compensation, Occupational Diseases Act or Law or any other act or law of similar purpose to which the City contributes, which provides the employee with a coverage for job-related accidental injuries and illnesses.

ERISA RIGHTS STATEMENT

As a Covered Person in the City's Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan Covered Persons shall be entitled to:

- Examine all Plan Documents without charge in the City Clerk's Office.
- Obtain copies of the Plan Documents within thirty (30) days after your written request is received by the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.
- File suit in a Federal Court, if any materials requested are not received within thirty (30) days of the Covered Person's request, unless the materials were not sent because of matters beyond the control of the Plan Administrator. The Court may require the Plan Administrator to pay up to $100 for each day's delay until the materials are received.

Persons who are responsible for the operation of the Employee Benefit Plan are referred to as "Fiduciaries" in the Law. Fiduciaries must act solely in the interest of the Plan's Covered Persons and they must exercise prudence in the performance of the Plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan. You may not be fired or discriminated against in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If you are improperly denied a welfare benefit in full or in part, you have a right to file suit in a Federal or State Court. If Plan fiduciaries are misusing the Plan's money, you have a right to file suit in a Federal Court or to request assistance from the U.S. Department Of Labor. If you are successful in your lawsuit, the Court may, if it so decided, require the other party to pay your legal costs, including attorney's fees.

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

PLAN SUMMARY

This Booklet summarizes the basic provisions of the City's Health Benefit Plan for you and your eligible dependents. The benefits described in these pages take precedence over, and replace any previous literature furnished. Requests for amounts of coverage other than those to which you are entitled in accordance with this Summary Plan Description cannot be accepted. This Booklet is a summary of the principal features of the Plan, but the Plan Document on file in the City Clerk's Office is the governing document. In the event of any variation between the information in this Summary Plan Description and the provisions of the Plan Document, the latter will prevail.

PLAN ADMINISTRATION

The administration of the Plan is under the supervision of the Plan Administrator. The City Clerk of the Plan Sponsor is the person who has been designated to act on behalf of the Plan Administrator.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. The Plan may also delegate its discretionary authority.

The Plan Sponsor will bear its incidental costs of administering the Plan.

Power and Authority of Claims Administrator

The Plan Sponsor has contracted with PersonalCare Insurance of Illinois, Inc. (“Claims Administrator”) to administer the Plan’s group health benefits. The Claims Administrator is responsible for (1) initial determination of the amount of any benefits payable under the Plan, and (2) prescribing claims procedures to be followed and the claim forms to be used by Covered Persons. Plan Sponsor is ultimately responsible for providing Plan benefits.

Questions

If a Covered Person has any general questions regarding the Plan, please contact the Plan Administrator.

If Covered Person has questions concerning eligibility for, or the amount of, any benefit payable under the Plan, please contact the Claims Administrator.

General Information

This Employee Health Benefits Plan sponsored by City of Mattoon is intended to comply with the Welfare Benefit Plan Provisions of the Employee Retirement Income Security Act of 1974. The following information together with the information contained in this Booklet is provided in accordance with the requirements of the Act.

PLAN NUMBER (PN): 501

EMPLOYER IDENTIFICATION NUMBER (EIN): 37-6000648

The Plan Administrator (ERISA Section 3) is:
City Of Mattoon
208 North 19th Street
Mattoon, IL 61938
(217) 235-5654

The Agent for Service of Legal Process is:
City Of Mattoon
208 North 19th Street
Mattoon, IL 61938
(217) 235-5654

The Named Fiduciary is:
City Of Mattoon
208 North 19th Street
Mattoon, IL 61938
(217) 235-5654

Plan contributions for Employee and Dependent coverage are made by the City and the Employee.

The Plan Year begins January 1 and ends December 31.

Claims are processed in accordance with the Plan Document by PersonalCare Insurance of Illinois, Inc., 2110 Fox Drive, Champaign, Illinois; 217-366-1226 or 866-557-8751. Please contact the Claims Administrator at the telephone number on the back of the Plan identification card for questions or concerns regarding Covered Services or any required

procedure. Telephone numbers and addresses to request review of denied claims, register complaints, place requests for Prior Authorization, and submit claims are listed above.

Membership ID Card: Every Covered Person receives a membership ID card. Covered Persons need to carry the Plan ID card with them at all times and present it whenever Covered Person receives health care services. If a Plan ID card is missing, lost, or stolen, contact the Claims Administrator's Customer Service Department at 217-366-1226 or 866-557-8751 to obtain a replacement.

The Plan is self-funded by City Of Mattoon. The amount of contributions is determined by the Plan Administrator annually, based on the Plan's claim experience.

PLAN TERMINATION

The Plan Administrator may terminate, suspend, withdraw, amend or modify the Plan in whole or in part, with respect to any class or classes of employees at any time, with proper notification and subject to the terms of the Plan and any applicable laws.