To Our Employees:

This booklet has been prepared to describe The Ashland County-West Holmes Joint Vocational School District Medical, Prescription Drug, and Dental Benefits Plan.

The benefits described herein will be administered by Self-Funded Plans, Inc. The following pages contain all pertinent information relating to your benefits, including eligibility requirements and claims submission procedures. In the event of any discrepancies between the explanation of benefits as described in this booklet and the explanation as defined in the Plan Document, the terms of the Plan Document will govern.

It is important that you read this booklet so that you will understand your benefits. We hope that this booklet will serve to clarify your benefits and that the Plan will provide an increased feeling of security for you and your family.
<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>PPO</th>
<th>NON-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRESCRIPTION DRUG BENEFIT (through Caremark; up to greater of 100 quantity or 34-day supply) Co-Pay Per Prescription</td>
<td>100% after co-pay per prescription, filled or refilled</td>
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<tr>
<td></td>
<td></td>
<td>$5 Generic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$10 Brand Name</td>
</tr>
<tr>
<td>MAIL ORDER DRUG BENEFIT (through Caremark; up to a 90-day supply) Co-Pay per Prescription</td>
<td>100%</td>
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<tr>
<td></td>
<td></td>
<td>$5 Generic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$10 Brand Name</td>
</tr>
<tr>
<td>ROUTINE PREVENTATIVE CARE BENEFIT</td>
<td>100%, deductible waived</td>
<td></td>
</tr>
<tr>
<td>ROUTINE PHYSICAL EXAM BENEFIT</td>
<td>100%, deductible waived, to max benefit of $75 every 24 months*</td>
<td></td>
</tr>
<tr>
<td>CALENDAR YEAR DEDUCTIBLE</td>
<td>$150 per person</td>
<td>$250 per family</td>
</tr>
<tr>
<td>BENEFIT PERCENTAGE PAYABLE, unless Shown as different percentage MAXIMUM OUT-OF-POCKET AMT PER CALENDAR YEAR (The PPO and Non-PPO Maximum Out-of-Pocket amounts are separate and shall not be applied toward each other.) The Maximum Out-of-Pocket amount does not include deductibles or co-pays or Outpatient treatment of mental/nervous disorders, alcoholism and/or drug addiction</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>$300 per person</td>
<td>$800 per person</td>
</tr>
<tr>
<td>EMERGENCY ROOM (NON-EMERGENCY)</td>
<td>90% after deductible subject to $50 co-pay**</td>
<td>80% after deductible subject to $50 co-pay**</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>$1,000,000***</td>
<td></td>
</tr>
</tbody>
</table>

* This maximum benefit does not apply for bus drivers, van drivers and Asbestos Program Managers.

** Co-pay is waived if Covered Person is admitted; if due to an accidental Injury or Medical Emergency; or if the Physician advises the Covered Person to go to the emergency room for treatment.

*** $15,000 calendar year maximum for Inpatient treatment of mental/nervous disorders. $15,000 calendar year maximum for Inpatient treatment of alcoholism and/or drug addiction. $30,000 lifetime maximum benefit for Inpatient treatment of mental/nervous disorders. $30,000 lifetime maximum benefit for Inpatient treatment of alcoholism and/or drug addiction.

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

**Calendar Year Deductible**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I &amp; Orthodontic Services</td>
<td>None</td>
</tr>
<tr>
<td>Class II &amp; III Services Combined</td>
<td>$50 PER PERSON</td>
</tr>
<tr>
<td></td>
<td>$150 PER FAMILY</td>
</tr>
</tbody>
</table>

**Benefit Percentages**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I Services</td>
<td>100% of reasonable charge</td>
</tr>
<tr>
<td>Class II Services</td>
<td>80% of reasonable charge</td>
</tr>
<tr>
<td>Class III Services</td>
<td>50% of reasonable charge</td>
</tr>
<tr>
<td>Orthodontic Services</td>
<td>50% of reasonable charge</td>
</tr>
</tbody>
</table>

**Maximum Benefit Payable Per Calendar Year**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Maximum Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I, II &amp; III Services Combined</td>
<td>$1,000 PER PERSON</td>
</tr>
</tbody>
</table>

**Maximum Lifetime Benefit**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Maximum Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontic Services</td>
<td>$1,500 PER PERSON</td>
</tr>
</tbody>
</table>
The Pre-Admission/Post-Admission Notification Program will be administered by:

Medillume III, Inc.
1444 Hamilton Avenue
Cleveland, Ohio  44114
(216) 575-5370
(800) 919-3311

This Program does not apply to Covered Persons for whom Medicare pays its benefits as primary carrier. If this Program is not followed by the Covered Person, a penalty of $200 will be applied to the Hospital confinement. No penalty will be applied for the failure to call Medillume III, Inc. for any Hospital stay in connection with childbirth for the mother or newborn child, provided such stay is less than forty-eight (48) hours following a normal vaginal delivery or less than ninety-six (96) hours following a cesarean section. The penalty will apply for the failure to call Medillume III, Inc. for any Hospital stay in connection with childbirth for the mother or newborn child if such stay is forty-eight (48) hours or more following a normal vaginal delivery or ninety-six (96) hours or more following a cesarean section. Instructions for using this program are as follows:

Non-Emergency Hospital Admission. As soon as the Covered Person is told that he needs to be admitted to a Hospital, he must call Medillume III, Inc. prior to the admission.

Emergency Hospital Admission. If the Covered Person is admitted to the Hospital on an Emergency basis, the call to Medillume III, Inc. must be made within 72 hours of the admission. This call can be made by the Covered Person, the Covered Person's Physician, a member of the Covered Person's family or other person designated by the Covered Person, or an authorized Hospital staff member.

Observation. If the Covered Person is in observation status for a period of twenty-four (24) hours or more, it will be treated as an admission for purposes of this Program.

The person calling Medillume III, Inc. will need to provide the name, address and birthdate of the patient; the names and telephone numbers of the Physician and Hospital; and the reason for the hospitalization. Each Covered Person is responsible for informing the attending Physician of the requirements of the Pre-Admission/Post-Admission procedures. A representative of Medillume III, Inc. may contact the Physician to discuss the proposed admission and treatment plan. If the diagnosis and treatment meet the criteria for Inpatient Hospital care, the representative and the patient's Physician will discuss the length of time expected in the Hospital, as well as any alternative types of care appropriate for recovery. A Partial Confinement will also be subject to the terms of this Program. If the Covered Person needs to be hospitalized longer than the period of which Medillume III, Inc. was previously notified, the Covered Person's Physician must notify Medillume III, Inc. of the additional days. The Pre-Admission/Post-Admission Notification Program does not guarantee benefits. All benefits are subject to the terms of this Plan. The Pre-Admission/Post-Admission Notification Program applies to each Hospital admission, and if a patient is transferred from one Hospital to another Hospital, the same procedures will need to be followed for each Hospital confinement. If the patient is unconscious or unable to follow the requirements of this Program due to Illness or Injury rendering the patient physically or mentally incapable, the penalty will be waived until the patient is able to follow the terms of the Program.

CASE MANAGEMENT

Case management coordinates care between the Covered Person and Physicians, facilities and other providers. Case management will be instituted by the Plan when the Plan determines that it would be appropriate (based on diagnosis, procedures and/or ongoing treatment). If case management is implemented, each Covered Person is required to participate in it and to fully cooperate with the case manager. When case management is instituted, the case manager will obtain information from the Physician(s), discharge planner(s), social worker(s) and/or other providers of health care services and supplies. The case manager will attempt to identify options that will preserve the Covered Person's benefits. Case management options will be communicated to the Covered Person, Eligible Employee, family member(s) and/or Physician(s). If a case manager recommends a type of treatment or program that is not normally covered under this Plan, and the Plan Administrator agrees to provide such coverage, such treatment or program will be considered to be a covered expense under this Plan. The Covered Person, the Covered Person's legal guardian, if any, or the Eligible Employee always has the option to pursue the treatment program of choice; however, the case manager will identify which treatment programs will be covered under the Plan.

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFITS

PREFERRED PROVIDER PLAN

This Plan utilizes a preferred provider organization by the name of Medical Mutual of Ohio SuperMed Plus ("PPO"). For purposes of this Plan, the term "PPO Provider" means a Physician, Hospital or other provider that has an agreement with the PPO to provide supplies or services at negotiated rates. The Plan will allow the amount which is negotiated between the PPO and its PPO Providers. If there is a per diem rate that is negotiated between the PPO and a PPO Provider, the Plan will cover the per diem amount. Services provided by non-PPO providers will be payable at the non-PPO level of benefits, unless one or more of the following conditions apply:

1. The Covered Person resides or is traveling outside of the service area of the PPO network (as determined by the Plan Administrator). This provision shall not apply if the reason for the travel was to obtain such services or supplies.
2. The Covered Person requires treatment for an accidental Injury or Medical Emergency and cannot reasonably obtain such treatment from a PPO provider or cannot express a provider preference due to his medical condition. The PPO level of benefits will apply until the Covered Person’s condition has sufficiently stabilized so that transfer to a PPO provider for any required continued treatment is reasonably possible.

3. The Covered Person receives, at a PPO facility, professional services for pathology, radiology or anesthesiology, or the services of an assistant surgeon or emergency room Physician.

To determine which providers belong to the PPO, Covered Persons can call the PPO at (800) 601-9208. The website address is www.supermednetwork.com.

PRESCRIPTION DRUG BENEFIT
The Prescription Drug Benefit covers drugs which may be lawfully dispensed only upon the written prescription of a Physician licensed to practice medicine, and which are dispensed at a Caremark pharmacy. Injectable insulin is also covered. Drugs which are not dispensed at a Caremark pharmacy will not be covered.

Each Covered Person will receive a prescription drug identification card. When a Covered Person presents the card to a Caremark member pharmacy, he need only pay the pharmacist the amount shown as the co-pay in the Schedule of Comprehensive Major Medical Expense Benefits for any prescription, filled or refilled.

If the Covered Person is not in possession of his card, a Prescription Drug Claim Form must be completed by the Covered Person and the pharmacist. The completed form should then be filed with Caremark, which will reimburse the Eligible Employee as long as the pharmacy is a Caremark member pharmacy.

The Employer may choose to administer the prescription drug program on a reimbursement basis, without the use of Caremark. If this is the case, the Eligible Employee will submit drug expenses on a medical claim form and be reimbursed by the Plan for eligible prescription drug expenses at the rate of 100%, after the prescription drug co-pay, per prescription (filled or refilled), has been satisfied, provided the pharmacy is a Caremark member pharmacy.

The following charges are excluded under this benefit: hypodermic needles and syringes; drugs prescribed in connection with occupational related injuries; Experimental drugs; drugs furnished by a Hospital, sanitarium or Skilled Nursing Facility; refilling of a prescription in excess of the number specified by the Physician; drugs not reasonably necessary for the patient's medical care; that portion of a single purchase of any drug which exceeds a 34-day supply or 100 unit doses (whichever is greater) when consumed or used in accordance with the directions of the prescribing Physician; therapeutic devices and appliances; immunization devices; biological sera; the administration of drugs, medicines or injectable insulin; and contraceptive drugs or devices, regardless of their intended uses.

MAIL ORDER DRUG BENEFIT
The Mail Order Drug program will be administered by the Caremark Mail Service Pharmacy network. This benefit covers a ninety (90) day supply of many maintenance medications, subject to the co-pay per prescription that is specified in the Schedule of Comprehensive Major Medical Expense Benefits.

ROUTINE PREVENTIVE CARE BENEFIT
This benefit covers the following routine services:

Well baby care to twelve (12) months of age, all care payable at 100% UCR, no deductible;

One (1) routine pap smear test and office visit per calendar year for all Covered Persons, payable at 100% UCR, no deductible;

One (1) routine mammogram and office visit for Covered Persons age thirty-five (35) through age forty (40); one (1) routine mammogram every two (2) years for Covered Persons age forty-one (41) to fifty (50); and one (1) routine mammogram per calendar year for Covered Persons age fifty (50) and over, payable at 100% UCR, no deductible;

One (1) routine Prostate Specific Antigen (P.S.A.) blood test every two (2) years for Covered Persons age forty (40) and over (including laboratory and office visit charges);

One (1) routine SM-23 and one (1) routine urinalysis test every two (2) years for all Covered Persons (including laboratory and office visit charges);

One (1) chest x-ray and one (1) complete blood count when incurred in connection with a routine physical examination (laboratory charges only).

ROUTINE PHYSICAL EXAMINATION BENEFIT
A benefit is payable at 100% of UCR, not subject to the deductible, for Physicians' office visit charges for one (1) routine physical examination in any twenty-four (24) consecutive month period, limited to a maximum benefit of $75. This benefit will only be payable for Eligible Employees and their Eligible Dependent spouses.
A benefit will be payable at 100% of the UCR for all Physicians’ office visits and laboratory charges incurred in connection with one (1) physical examination per calendar year for any Employee assigned as a bus driver or a van driver. No deductible will apply to this benefit.

A benefit will be payable at 100% of the UCR for all Physicians’ office visits and laboratory charges incurred in connection with one (1) physical examination and one (1) asbestos physical examination per calendar year for any Employee assigned as both a bus driver and Asbestos Program Manager. No deductible will apply to this benefit.

A benefit will be payable at 100% of the UCR for all Physicians’ office visits and laboratory charges incurred in connection with one (1) asbestos physical examination per calendar year for any Employee assigned as an Asbestos Program Manager. No deductible will apply to this benefit.

$50 EMERGENCY ROOM CO-PAYMENT
A $50 co-payment will be applied to every emergency room visit. This co-payment is in addition to the calendar year deductible. However, the $50 co-payment will be waived if the Covered Person is admitted to the Hospital; if the Covered Person’s Physician has advised him to go to the emergency room for treatment; or if the Covered Person uses the emergency room for treatment of an accidental Injury or Medical Emergency (as defined herein). Warning signs of a Medical Emergency include, but are not limited to:

* bleeding that will not stop;
* severe pain or pressure in the abdomen or chest;
* gasping for breath;
* coughing up or vomiting blood;
* severe or persistent vomiting;
* suicidal or homicidal feelings;
* change in mental status (confusion, unusual behavior);
* unconsciousness following a head Injury.

BENEFIT PERCENTAGE PAYABLE/MAXIMUM OUT-OF-POCKET AMOUNT
Eligible Expenses are payable at the percentage rates shown in the Schedule of Comprehensive Major Medical Expense Benefits. Once the Maximum Out-of-Pocket Amount is reached, then Eligible Expenses will be payable at 100% for the balance of that calendar year. The Maximum Out-of-Pocket Amount includes only coinsurance paid by the Covered Person. It does not include deductibles, co-pays, Outpatient treatment of mental/nervous disorders, alcoholism and/or drug addiction; penalties; or charges that are excluded or that exceed limits outlined in this Plan. The Maximum Out-of-Pocket Amounts are separate for PPO and non-PPO providers and will not be applied toward each other. Any reference in this Plan to a 90% benefit shall be modified to reflect a 90% benefit for PPO providers and an 80% benefit for non-PPO providers.

Deductible
The deductible is the amount of covered medical expenses which each Covered Person must pay before benefits are provided under these provisions. The deductible amount is specified in the Schedule of Comprehensive Major Medical Expense Benefits. The deductible applies only once during any calendar year, even though a person may have several different accidents or Illnesses.

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

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

Eligible Expenses For All Other Covered Charges
The following services and supplies are also covered expenses under this Plan:

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

2. Physicians’ charges for treatment of an Illness or Injury (including charges for an elective sterilization). For surgery claims, the allowable amount for an assistant surgeon will be 20% of the allowance for the primary surgeon, and Medicare RBRVS will be used to determine allowable amounts for (1) multiple surgeries performed on the same day or at the same session; (2) bilateral surgeries; (3) co-surgery and team surgery; and (4) services rendered by a Physician’s Assistant. Charges for Outpatient treatment of mental/nervous disorders, alcoholism and/or drug addiction will always be payable at 90% (and never 100%). Such charges include, but are not limited to, individual, group and family counseling. The attending Physician must certify the need for treatment after the first three (3) months before additional benefits can be covered.
3. Charges for medical supplies and the rental of surgical equipment including crutches, braces, medical appliances and artificial limbs or Durable Medical Equipment under a lease acceptable to the Plan (as prescribed by the attending Physician).
4. Charges for the services of a registered professional nurse (R.N.) and for the services of a licensed practical nurse (L.P.N.) other than a Close Relative.
5. Charges for such drugs and medicines which can be purchased only upon a Physician's prescription, and which are not paid under the Prescription Drug Benefit or Mail Order Drug Benefit.
6. Charges for blood transfusions, blood and blood plasma, to the extent it is not donated or otherwise replaced, and blood storage and processing.
7. Charges for treatment of jaw joint problems including temporomandibular joint dysfunction (TMJ) syndrome and conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint. Covered services include, but are not limited to: orthopedic (not orthodontic) appliances and physical therapy.
8. Charges for orthoptics.
9. Charges for care rendered in an Urgent Care Facility.
10. Charges for occupational therapy prescribed by the attending Physician as to type and duration when performed by a licensed occupational therapist (however, supplies incurred in connection with occupational therapy are not covered).
11. Charges for a Physician's or speech therapist's fees for restoratory or rehabilitory speech therapy for speech loss or impairment due to an Illness or Injury, other than a functional nervous disorder, or due to surgery performed on account of an Illness or Injury. If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.
12. Charges for chemotherapy and x-ray, radium and radioactive isotope therapy.
13. Charges for professional ambulance service when used in emergency situations to transport a Covered Person from the place of accidental Injury or acute medical episode to the nearest Hospital where required treatment is given. Ambulance charges incurred to transport a Covered Person from one Hospital to another Hospital will be covered only if the first Hospital is not equipped to treat the Covered Person's medical condition. Ambulance charges will only be covered if the attending Physician certifies that such transportation is Medically Necessary.
14. Charges incurred for treatment rendered by a licensed or certified massotherapist, to a maximum of twelve (12) visits per calendar year.
15. Charges for a Hospital Outpatient department cardiac rehabilitation program, limited to a maximum benefit of $1,000 per calendar year. This benefit will only be payable if all of the following conditions have been met:
   a) the person has myocardial infarction, has had coronary bypass surgery, has stable angina pectoris; angioplasty; or a heart transplant;
   b) the person starts his cardiac rehabilitation program within twelve (12) months after discharge from a Hospital stay that is due to one of the above conditions; and
   c) the cardiac rehabilitation program is rendered in the Hospital's Outpatient department or in a Medicare-approved facility for cardiac rehabilitation.
16. Charges for periodic review of a child's physical and emotional status performed by a Physician or by a health care professional under the supervision of a Physician. Such periodic review charges will include coverage for a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests that are not treating an Illness or Injury. Benefits for the above charges that are provided to a child during any year thereafter from age one (1) to age nine (9) shall not exceed a maximum limit of $150 per calendar year.
17. Charges for physical therapy prescribed by the attending Physician as to type and duration when performed by a licensed physical therapist.
18. Charges for anesthesia and the administration thereof.
19. Charges for oxygen and the administration thereof.
20. Charges for diagnostic x-ray and laboratory examinations.
22. Charges for care in an Alcoholism Treatment Facility (payable as if such charges were incurred in a Hospital).
23. Charges for care rendered in an Ambulatory Surgical Center.
24. Charges for home care visits rendered through a Home Health Care Agency, provided that the Physician certifies the medical necessity of home health care. The allowed home care services are the usual and customary services of the Home Health Care Agency which are not specifically excluded hereunder and services provided on an Outpatient basis in a Hospital when such services cannot readily be made available at the Covered Person's place of residence. The following services and supplies are covered: part-time or intermittent nursing care and initial evaluation; physical, occupational and speech therapy; medical social services; part-time or intermittent services of home health aides; dietary guidance; medical services and supplies necessary for the treatment of a condition for which the home health care service is required; the use of medical appliances; and services provided on an ambulatory care basis when such services cannot readily be made available in the Covered Person's home. Notwithstanding anything to the contrary herein set forth, home care services do not include: meals; professional medical services billed for by a Physician; Custodial Care; services of housekeepers; prescription and non-prescription drugs and biologicals; and services of a Close Relative or members of the Covered Person's household.
25. Charges for care rendered by a Hospice. Covered charges include room and board charged by the Hospice; miscellaneous services and supplies; part-time nursing care by or under the supervision of a registered graduate nurse; home health care services; and counseling services by a licensed social worker or a licensed pastoral counselor for the patient and the patient's Close Relatives. Such care is only covered if a Physician has certified that the patient is terminally ill and the patient's life expectancy is six (6) months or less.
26. Charges for services and supplies furnished in connection with covered transplant procedures, subject to the following conditions:
   a) If the recipient is covered under this Plan, eligible medical expenses incurred by the recipient will be considered for benefits. Expenses incurred by the donor, who is not ordinarily covered under this Plan according to participant eligibility requirements, will be considered eligible expenses to the extent that such expenses are not payable by the donor's plan. The donor's charges will be payable as if they had been incurred by the Covered Person.
   b) If both the donor and the recipient are covered under this Plan, eligible medical expenses incurred by each person will be treated separately for each person.
   c) The reasonable and customary cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, will be considered a covered expense.

27. Maternity charges. Covered charges include obstetrical services, prenatal and postnatal care. Charges for an elective abortion will also be covered under this benefit. Any services provided by a Nurse-Midwife acting within the scope of a license which allows for providing such services will be payable on the same basis as services provided by a Physician. Charges incurred in a Freestanding Birthing Facility will be payable as if they had been incurred in a Hospital. If an Employee has dependent coverage, the Plan covers the nursery charges for routine care for the newborn well baby while the baby is in the Hospital and provides coverage for medical care for an infant with an Illness, infection or serious birth defect. The Plan also covers charges for the baby's circumcision and the initial examination of the newborn well baby.

28. Charges for care in a Skilled Nursing Facility if a Physician determines that the Covered Person requires skilled nursing care. In order for this benefit to be payable, the Covered Person must be confined in a Skilled Nursing Facility within fourteen (14) days following a Hospital confinement that lasted at least three (3) days. Charges for room and board (at the Semi-Private Room Rate) and necessary services and supplies will be covered for up to a maximum period of sixty (60) days per calendar year.

29. Charges for peritoneal dialysis, renal dialysis or other dialysis procedures performed at the Covered Person's home or on an Inpatient or Outpatient basis in a Hospital or Freestanding Dialysis Facility. Dialysis performed to treat drug addiction will be subject to the limits outlined in the Plan for such drug addiction treatment.

MAXIMUM BENEFIT

The Maximum Lifetime Benefit payable per person for Major Medical Expense Benefits and Basic Medical Expense Benefits combined is specified in the Schedule of Comprehensive Major Medical Expense Benefits. The Maximum Lifetime Benefit payable per person for the Inpatient treatment of mental/nervous disorders, alcoholism and/or drug addiction is specified in the Schedule of Comprehensive Major Medical Expense Benefits. The Maximum Lifetime Benefit applies only to charges incurred while the person is covered under this Plan.

PRE-EXISTING CONDITION LIMITATION

The Pre-Existing Condition Limitation applies to Covered Persons who were eligible for coverage and did not enroll within thirty-one (31) days on or after January 1, 1998.

A Pre-Existing Condition is any Injury or medical condition for which diagnosis, care and/or treatment is received by a Covered Person during the three (3) month period ending on the effective date of coverage. In the event of a Pre-Existing Condition, benefits will not be payable until one of the following occurs:

1. A period of three (3) consecutive months ending after the effective date has elapsed, during which the Covered Person has not received any care or treatment in connection with such Illness or Injury, or
2. A period of twelve (12) months has elapsed during which the Covered Person has been continuously covered under the Plan.

In the event that an adoption or Placement for adoption of a child occurs while an Eligible Employee is eligible for coverage under this Plan, the Pre-Existing Condition Limitation shall not apply to the child being adopted or Placed for adoption. For the purpose of this paragraph, the term "Placed" or "Placement" shall mean the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's Placement terminates upon the termination of such legal obligation.

MEDICAL PLAN LIMITATIONS AND EXCLUSIONS

The Plan will not pay benefits for or give credit for expenses that are not covered expenses, nor will the Plan pay benefits for or give credit for any expense if the confinement, service or supply is for:

1. Care for occupational Injury or Illness for which any Workers' Compensation benefits are available.
2. Charges for dental care (unless such treatment is dental surgery and is rendered as a result of an accidental Injury to sound, natural teeth sustained while covered under the Employer's Plan). However, if it is Medically Necessary that a Covered Person be treated at a Hospital for treatment of a dental condition, the Hospital charges will be a covered expense.
3. Charges for Custodial Care.
4. Charges for care in any Hospital owned or operated by any federal government, with the exception of charges for care in a V.A. Hospital for veterans who have non-service-connected disabilities or charges for Inpatient care in a military hospital by military retirees, dependents of retirees and dependents of active military personnel.

5. Charges for Hospital room and board and general nursing care when the Covered Person is admitted primarily for diagnostic study or medical observation and the necessary care can properly be provided on an Outpatient basis.

6. Charges for Cosmetic Surgery, except services performed to improve a body function, treat a scar caused by an Injury or surgery, or to correct a birth defect.

7. Charges for routine foot care, which include treatment of bunions (except by capsular or bone surgery), toe nails (except surgery for ingrown nails), corns, calluses, fallen arches, flat feet, weak feet, chronic foot strain, symptomatic complaints of the feet, purchase of orthopedic shoes or orthotics that are prescribed to treat a foot condition that is not covered. However, this exclusion will not apply to treatment of skin of the feet or toenails if the patient is diabetic.

8. Charges for immunizations (except as specified herein).

9. Charges for weekend admissions (Friday, Saturday). Unless the Hospital bill is accompanied by documentation supporting the need for immediate Hospital admission beginning on a Friday or Saturday, Hospital room and board charges for one (1) or both of those days will not be covered.

10. Charges for non-prescription or over-the-counter drugs or dietary supplements.

11. Charges for Experimental or investigational procedures.

12. Charges which were incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.

13. Charges for services which are not performed according to accepted standards of medical practice for the condition being treated.

14. Charges for Preventive/Maintenance Care, routine physical examinations and immunizations (except as specified herein).

15. Charges for personal services not required in the diagnosis or treatment of an Illness or Injury. Such charges for personal services include charges incurred during a Hospital confinement such as television rental, telephones, barber services or guest meals.

16. Charges for services rendered primarily for training or educational purposes.

17. Charges for eyeglasses or hearing aids, or the examination for their prescription or fitting, except due to accidental Injury occurring while this Plan is in effect, or if the charges are incurred in connection with cataract surgery.

18. Charges for services which are in excess of the Usual, Customary, and Reasonable Charge.

19. Charges for services which are not Medically Necessary or which have not been recommended by a Physician.

20. Charges for services rendered by a Physician, nurse or licensed therapist if such Physician, nurse or licensed therapist is a Close Relative of the Covered Person, or resides in the same household as the Covered Person.


22. Charges for in vitro fertilization, artificial insemination, fertility drugs or contraceptives.

23. Charges for the reversal of an elective sterilization.

24. Charges for any services received as a result of Injury or Illness due to an act of war which has occurred after the effective date of the Covered Person's coverage, or caused during service in the armed forces of any country.

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

26. Charges for enrollment in a health, athletic, or similar club or a weight loss program.

27. Charges for purchase or rental of supplies of common use such as exercise cycles, air purifiers, air conditioners, water purifiers, hypoallergenic pillows or mattresses or waterbeds.

28. Charges for purchase or rental of escalators or elevators, saunas, steam baths, swimming pools, or blood pressure kits.

29. Charges for sex transformation and hormones related to such treatment and charges for related psychiatric care.

30. Charges for radial keratotomy, refractive keratoplasty, or any other procedure done to correct nearsightedness or farsightedness.

31. Charges for chelation therapy, except as approved by the Food and Drug Administration.

32. Charges for materials used in occupational therapy.

33. Charges incurred in connection with travel expenses of a Covered Person (other than as specified herein) or a provider.

34. Charges for replacements for artificial limbs, crutches, braces, and other medical appliances, except in the case of dependent children when the Physician certifies that such replacement is necessary.

35. Charges for any services or supplies incurred in connection with treatment of nicotine addiction.

36. Charges for prescription drugs that are covered under the Prescription Drug Benefit or Mail Order Drug Benefit.

DENTAL EXPENSE BENEFITS

Dental Expense Benefits are designed to help each Covered Person meet his or her expenses for services performed or supplies provided by a Dentist.

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

Deductible
The deductible is the amount of covered dental expenses which must first be paid by the Covered Person before benefits for Class II & III Services are payable. The deductible applies only once each calendar year.

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

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

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

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

**Benefits for Temporary Work**
Benefits for temporary dental service will be considered a part of the final dental service.

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

**Covered Dental Expenses**
Covered Dental Expenses are the Usual, Customary, and Reasonable Charges of a Dentist which the Employee is required to pay for services and supplies listed below which are received by a covered family member in connection with a course of treatment; but only to the extent that the Plan determines that the services rendered and supplies furnished and the course of treatment are:

a. appropriate and meet professionally recognized national standards of quality; and
b. are necessary for the treatment of a non-occupational Illness or a non-occupational Injury and are customarily employed nationwide for the treatment of the dental condition;
taking into account the current total oral condition of the covered family member.

The following is a complete list of those dental services which will be considered as Covered Dental Expenses:

**Class I Services (Preventive & Diagnostic)**
1. Oral examination, but not more than two (2) examinations in any twelve (12) month period.
2. Prophylaxis (the cleaning and scaling of teeth), but not more than two (2) prophylaxis treatments in any twelve (12) month period.
3. Topical application of sodium or stannous fluoride; but not more than once in any twelve (12) month period.
5. Space maintainers.
6. Diagnostic tests, x-rays and laboratory examinations.

**Class II Services (Basic Restorative)**
1. Fillings (amalgam and silicate).
2. Endodontic treatment, including root canal therapy.
3. Treatment of periodontal and other diseases of the gums and tissues of the mouth.
4. Repair or recementing of crowns, inlays, bridgework, or dentures; or relining of dentures.
5. Extractions.
6. Oral surgery (excluding any charges which are covered under the medical benefits plan).
7. General anesthetics administered in connection with oral surgery, only if Medically Necessary.
8. Injections of antibiotic drugs by the attending Dentist.

**Class III Services (Major Restorative)**
1. Inlays, onlays, gold fillings, and crowns.
2. Initial installation of fixed bridgework (including inlays and crowns to form abutments).
3. Initial installation of partial or full removable dentures.
4. Replacement of an existing partial or full removable denture or fixed bridgework by a new partial or full removable denture or fixed bridgework, or addition of teeth to an existing partial denture, unless excluded herein.

Orthodontic Services
The term Orthodontic Procedure means the use of active appliances to move teeth, to correct faulty position of teeth (malposition), to correct abnormal bite (malocclusion), or to control harmful habits.

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

A charge is an Eligible Charge if all these conditions are met:
1. It is made for a service or supply furnished in connection with an orthodontic procedure and before the end of the estimated duration shown in the orthodontic treatment plan.
2. An active appliance for that orthodontic procedure is inserted while the person is covered for this benefit.
3. The orthodontic procedure is needed to correct one of these conditions:
   a. vertical or horizontal overlap of upper teeth over lower teeth (overbite or overjet) of at least four (4) millimeters; or
   b. faulty alignment (either frontwards or backwards) of the upper and lower arches with each other by at least the width of one (1) tooth section (one [1] cusp); or
   c. cross-bite; or
   d. control harmful habits.

No benefit will be payable for any charges for an orthodontic procedure if an active appliance has been installed before the first day on which the person became covered for this benefit.

Orthodontic benefits will be paid in equal installments every month. The first monthly period will start on the date an active appliance is installed. The initial down payment will be payable at 20% of the total charge, payable at the coinsurance percentage. If orthodontic treatment is stopped for any reason before it is complete, the benefit will only pay for services and supplies actually received.

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

Dental Plan Limitations and Exclusions
Dental Expense Benefits do not cover expenses incurred for any of the following:
1. Charges for dental care which is provided solely for the purpose of improving appearance, when form and function of the teeth are satisfactory and no pathological condition exists, including charges for personalization or characterization of dentures.
2. Charges for treatment by other than a Dentist, except that cleaning or scaling of teeth and topical application of fluoride may be performed by a licensed Dental Hygienist, if such treatment is rendered under the supervision and direction of the Dentist.
3. Charges for dental care which does not meet the standards of dental practice accepted by the American Dental Association.
4. Charges for the replacement of a lost, stolen, spare or duplicate prosthetic device.
5. Charges for sealants, for oral hygiene instructions or dietary instruction, for implantology and for plaque control program.
6. Charges for appliances or restorations, other than full dentures, whose primary purpose is to increase vertical dimension or stabilize periodontally involved teeth, or to restore the occlusion.
7. Charges for services or supplies which are furnished prior to the effective date of coverage. In the case of prosthetic devices and crowns, charges will not be covered if the impressions were taken before the date coverage commenced, even though the prosthetic device or crown is not installed until after the date coverage commenced.
8. Charges for replacement of a crown, bridge or denture within five (5) years following the date of its original installation unless such replacement is made necessary by the placement of an original opposing full denture or the extraction of natural teeth; or the bridge or denture, while in the oral cavity, has been damaged beyond repair as a result of an Injury received while the Covered Person is covered under the Employer's Plan.

9. Charges for dental care arising out of or in the course of employment for pay or profit or which is covered by Workers' Compensation or a similar law.

10. Charges for dental care which is furnished while a person is confined in a Hospital operated by the United States Government or any agency thereof (except in a foreign country), or dental care for which the person would not be required to pay if there were no benefits.

11. Charges which the person is not legally required to pay.

12. Charges which are in excess of the Usual, Customary, and Reasonable Charge.

13. Charges for appointments not kept, or for the completion of claims forms.

14. Charges for adjustment or repair to a denture performed within six (6) months of the installation of the denture.

15. Charges for anesthesia, except when considered Medically Necessary and administered in connection with oral or dental surgery.

16. Charges for dental care not included in the list of defined eligible expenses.

17. Charges related to services or supplies of the type normally intended for sport or home use.

18. Charges for dental care resulting from any Injury sustained as a result of war, declared or undeclared.

19. Charges made by a Dentist or Dental Hygienist who normally lives in the Covered Person's home, or is a Close Relative.

20. Charges, if any, that are included as covered medical expenses.

**ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE**

All Eligible Employees who are enrolled on the effective date of the Plan will be covered on that date.

New Eligible Employees who are enrolled will be covered on the first day of the month coinciding with or next following the date of hire, provided they are Actively at Work on that date (if they are not actively working on that date, coverage begins on the first of the month following the date on which active work begins). If an Employee fails to enroll within thirty-one (31) days of becoming eligible, he will be required to submit proof of good health at his own expense and will be subject to the Pre-Existing Condition Limitation provision of this Plan. Acceptance into the Plan will be subject to Underwriting approval. If application is approved, coverage will be effective on the day it is approved. If an Employee is enrolling for coverage more than thirty-one (31) days after becoming eligible due to a change in family status (as described herein), the Pre-Existing Condition Limitation will not apply to such Eligible Employee and the proof of good health requirement will be waived.

Eligible Employees who return to work following a tour of active duty in a United States Military Reserve Unit will be covered on the date they return to work. Such Eligible Employees will continue to be covered under the Plan as if there had been no break in service, and a new Pre-Existing Condition Limitation will not apply to such Eligible Employees or their Eligible Dependents.

Eligible Dependents who are enrolled will be covered on the same date as the Eligible Employee or the date such dependent is acquired (whichever is later), subject to the terms described in the following paragraphs. A newborn of an Eligible Employee will be covered from the moment of birth, provided the newborn is properly enrolled into the Plan as a new dependent within ninety (90) days following the date of birth. Claims submitted for a newborn will not be processed until the newborn is properly enrolled. A spouse will be considered an Eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a dependent of the Eligible Employee within thirty-one (31) days of the date of marriage. If a dependent is acquired other than at the time of his birth, due to a court order, decree, or marriage, that dependent will be considered an Eligible Dependent of the Eligible Employee from the date of such court order, decree, or marriage, provided this new dependent is properly enrolled as a dependent of the Eligible Employee within ninety (90) days of the court order, decree, or marriage. However, if a dependent child is acquired as a result of adoption, that child will be covered the day he is Placed with the adopting parents during the period before the adoption becomes final, provided the child is properly enrolled as a dependent of the Eligible Employee within ninety (90) days of the date of eligibility. The term "Placed" or "Placement" shall mean the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's Placement terminates upon the termination of such legal obligation.

If an Eligible Employee enrolls a dependent for coverage more than ninety (90) days (for a dependent child) or thirty-one (31) days (for a dependent spouse) after the dependent is eligible for coverage, the Eligible Employee will be required to submit proof of good health for the dependent, at the Eligible Employee's expense, and the dependent will be subject to the Pre-Existing Condition Limitation provision of this Plan. Acceptance into the Plan will be subject to Underwriting approval. If the dependent's proof of good health is approved, his coverage will be effective on the day the proof of good health is approved. The Plan reserves the right to request any records deemed necessary to verify the eligibility of any dependent. If the Eligible Employee is enrolling a dependent for coverage more than ninety (90) days (for a dependent child) or thirty-one (31) days (for a dependent spouse) after becoming eligible due to a change in family status (as described herein), the Pre-Existing Condition Limitation provision of this Plan will not apply to such Eligible Dependent and the proof of good health requirement will be waived.

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

Changes in family status for which a benefit election change may be permitted include the marriage or divorce of the Eligible Employee; the death of an Eligible Employee's spouse or an Eligible Dependent; the birth or adoption of a child of the Eligible Employee; the termination of employment (or the commencement of employment) of the Eligible Employee's spouse; the switching from part-time to full-time employment status or from full-time to part-time status by the Eligible Employee or the Eligible Employee's spouse; or the taking of an unpaid leave of absence by the Eligible Employee or Eligible Employee's spouse. Benefit election changes are also permitted where there has been a significant change (as determined by the Plan Administrator) in the health coverage of the Eligible Employee, spouse, or ex-spouse attributable to the spouse's or ex-spouse's employment. Benefit election changes are consistent with family status changes only if the election changes are necessary or appropriate as a result of the family status change.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 PROVISION

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

TERMINATION OF COVERAGE

The coverage of any Covered Person shall terminate on the earliest of the following dates:

1. The date of termination of the Plan;
2. The last day of the month coinciding with or next following the date of termination of employment;
3. The date sick leave, or other approved leave of absence, is exhausted (based on the Employer's policy in effect at the time of the leave);
4. The date all coverage or certain benefits are terminated on a particular class by modification of the Plan;
5. The end of the month following the last day in which an Employee receives a paycheck from the Employer;
6. The end of the month following the date the Employee fails to make any required contribution for coverage;
7. The end of the month following the date an Eligible Employee retires; or
8. With respect to an Eligible Dependent, the date coverage terminates for the Eligible Employee or the date such Dependent no longer meets the qualifications of an Eligible Dependent.

THE FAMILY AND MEDICAL LEAVE ACT OF 1993

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

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

In the event that an Eligible Employee does not continue benefits under this Plan throughout an approved FMLA leave, the Continuation of Coverage Provision (COBRA) outlined in the Plan will apply to such Eligible Employee in accordance with the following paragraph.

The Continuation of Coverage Provision (COBRA) outlined in the Plan will apply on the earliest of:
1. The date that the Eligible Employee informs the Employer of his intent not to return from such leave; or
2. The date that the Eligible Employee does not return from such leave after the leave is over.

CONTINUATION OF COVERAGE PROVISION (COBRA)

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

ELIGIBILITY FOR CONTINUATION. A person who is eligible for continuation coverage is called a "Qualified Beneficiary." The events making a person eligible for continuation coverage are called "Qualifying Events." For a covered employee to become a Qualified Beneficiary, the employee must become ineligible for group coverage because of a Qualifying Event consisting of a termination of the employee's employment (other than because of gross misconduct) or because of a reduction in the number of hours worked.

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

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

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

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

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

1. The end of:
   a. eighteen (18) months, in a case where the Qualifying Event was a termination of employment or a reduction in hours; or
   b. thirty-six (36) months, for other Qualifying Events;
2. The date on which the Employer ceases to provide any group health plan to any Eligible Employee;
3. The date on which coverage ceases under the Plan due to the Qualified Beneficiary's failure to make timely payment of any required premium;
4. The date on which the Qualified Beneficiary first becomes, after the date of election:
   a. a covered person under any other group health plan. If the other group health plan contains an exclusion or limitation relating to a pre-existing condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for continuation coverage as long as the exclusion or limitation relating to the pre-existing condition has not been satisfied or deemed to have been satisfied; or
   b. entitled to benefits under Medicare (under Part A, Part B, or both).

5. In the case of a Qualified Beneficiary who is determined by the Social Security Administration (hereinafter SSA) to be disabled, then continuation coverage may continue for up to twenty-nine (29) months for all Qualified Beneficiaries. This extension is available only for Qualified Beneficiaries who are receiving COBRA coverage because of a Qualifying Event that was the Eligible Employee's termination of employment or reduction of hours. The disability must have started at some time before the sixty-first (61st) day after the covered employee's termination of employment or reduction of hours, and must last at least until the end of the period of COBRA coverage that would be available without the disability extension. The disability extension is available only if the Qualified Beneficiary notifies the Plan in writing of the SSA determination of disability (based on the Notification of Qualifying Event procedures outlined herein) within sixty (60) days after the latest of (1) the date of the SSA disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; (3) the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours; or (4) the date on which the Qualified Beneficiary is informed, through the Plan's summary plan description or the general COBRA notice, of his or her obligation to provide notice and the procedures for providing such notice. The Qualified Beneficiary must also provide this notice within eighteen (18) months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. Required notification procedures are outlined in the section entitled "Notification of Qualifying Event." The Employer is authorized to charge the Qualified
Beneficiary an increased premium for continuation coverage extended beyond eighteen (18) months pursuant to this provision.
In the event that the Qualified Beneficiary is determined by SSA to be no longer disabled, the Qualified Beneficiary shall notify the Employer of this determination within thirty (30) days. This notification shall be satisfied by sending a copy of the SSA letter stating that the Qualified Beneficiary is no longer considered to be disabled by SSA.
If during extended coverage for disability (continuation of coverage months nineteen [19] - twenty-nine [29]) a Qualified Beneficiary is determined to be no longer disabled under The Act, continuation coverage shall terminate the last day of the month following thirty (30) days from the date of SSA’s final determination that the Qualified Beneficiary is no longer disabled.

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

ELECTION PERIOD. A Qualified Beneficiary may elect continuation coverage during the Election Period. The Election Period means the period which:
1. Begins not later than the date on which coverage terminates under the group plan because of the Qualifying Event; and
2. Is of at least sixty (60) days duration; and
3. Ends not earlier than sixty (60) days after the later of:
   a. the date coverage terminates under this Plan because of the Qualifying Event; or
   b. the date of the notice offering the election of continuation of coverage.

MULTIPLE QUALIFYING EVENTS. If during continuation coverage a Qualified Beneficiary experiences a subsequent Qualifying Event and the original Qualifying Event was termination of the Eligible Employee’s employment (other than for gross misconduct) or reduction in the number of hours of the Eligible Employee’s employment, then that Qualified Beneficiary may be eligible to participate in continuation coverage for up to thirty-six (36) months from the date of the original Qualifying Event. When Plan coverage is lost due to the end of employment or reduction of the Eligible Employee’s hours of employment, and the Eligible Employee became entitled to Medicare benefits less than eighteen (18) months before the Qualifying Event, COBRA coverage for the Qualified Beneficiaries (other than the Eligible Employee) who lose coverage as a result of the Qualifying Event can last up to thirty-six (36) months after the date of Medicare entitlement. For example, if an Eligible Employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the Qualifying Event (thirty-six [36] months minus eight [8] months). This COBRA coverage period is available only if the Eligible Employee becomes entitled to Medicare within eighteen (18) months before the termination or reduction of hours.
To report a subsequent Qualifying Event, the Qualified Beneficiary must send written documentation of the second Qualifying Event to the Employer within sixty (60) days of the later of (a) the occurrence of such Qualifying Event, or (b) the date on which the Qualified Beneficiary loses (or would lose) coverage as a result of the Qualifying Event, or (c) the date on which the Qualified Beneficiary is informed, through the Plan’s summary plan description or the general COBRA notice, of his or her obligation to provide notice and the procedures for providing such notice.
Required notification procedures are outlined in the section entitled “Notification of Qualifying Event.” If the required notification procedures are not followed, then there will be no extension of COBRA due to a second Qualifying Event.

CONVERSION FOLLOWING CONTINUATION. The Plan will make available to the Covered Person the option of enrolling in the medical conversion coverage available under the group health plan. In order for the conversion to be effective, application for the medical conversion coverage must be received by the insurance company during the time period designated by the insurer, and the first payment of the premium, as designated by the insurance company, must accompany the application.

NOTIFICATION OF QUALIFYING EVENT. The Covered Person is responsible for notifying the Employer of the occurrence of the following Qualifying Events:
1. divorce or legal separation of the Eligible Employee from the Eligible Employee’s spouse;
2. a dependent child ceasing to be an Eligible Dependent;
3. second qualifying events, entitling certain Qualified Beneficiaries to an extension of the COBRA maximum coverage period for up to thirty-six (36) months;
4. a Qualified Beneficiary’s disability, entitling Qualified Beneficiaries to an eleven (11) month extension of the COBRA maximum coverage period for up to twenty-nine (29) months; and
5. the end of a disabled Qualified Beneficiary’s disability (such that the eleven [11] month disability extension is no longer available).

Such notification must be made within sixty (60) days of the later of (a) the occurrence of such Qualifying Event; (b) the date on which there is a loss of coverage; (c) in the case of a Qualified Beneficiary’s disability, the date of the SSA disability determination; or (d) the date on which the Qualified Beneficiary is informed, through the Plan’s summary plan description or the general COBRA notice, of his or her obligation to provide notice and the procedures for providing such notice.
To report such Qualifying Events, the Covered Person must submit written documentation of the change to the Treasurer within the time period noted in this paragraph. The Covered Person must include copies of the relevant paperwork (i.e. the paperwork outlining the Medicare determination of disability, a copy of the divorce decree, etc). If the notification is deficient, the Employer
will request more complete information; if this request for information is not responded to within the required time period, the Notification will be rejected.

**TRADE ADJUSTMENT ASSISTANCE OR ALTERNATIVE TRADE ADJUSTMENT ASSISTANCE.** Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an Eligible Employee or former Eligible Employee becomes eligible for TAA or ATAA, but only if the election is made within the six months immediately after the individual's group health plan coverage ended. Employees or former employees who believe they qualify or may qualify for TAA or ATAA should contact the Employer promptly after qualifying for TAA or ATAA.

**FMLA.** If an Eligible Employee takes FMLA leave and does not return to work at the end of the leave, the Eligible Employee (and the Eligible Employee’s Eligible Dependents, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage within 18 months because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave). COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours.

**ELECTION PROCEDURES.** To elect COBRA, the Qualified Beneficiary must complete the Continuation Coverage Election Form and submit it to the Plan Supervisor. Under federal law, the Qualified Beneficiary must have sixty (60) days after the date of the COBRA election notice provided to the Qualified Beneficiary at the time of his Qualifying Event to decide whether he wants to elect COBRA under the Plan. The Continuation Coverage Election Form must be completed in writing and mailed or hand-delivered to the address shown on the form. If mailed, the election must be postmarked (and if hand-delivered, the election must be received by the individual at the Plan Supervisor’s office) no later than sixty (60) days after the date of the COBRA election notice provided to the Qualified Beneficiary at the time of the Qualifying Event. If the election is not submitted within these time periods, the individual will lose his right to elect COBRA. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual’s COBRA coverage; and electronic communications, including e-mail. If COBRA is rejected before the due date, the Qualified Beneficiary may change his mind as long as he furnishes a completed Election Form before the due date.

**DEFINITIONS OF KEY WORDS**

**ACTIVELY AT WORK:** An Employee shall be considered “Actively at Work” if he reports for work on the date in question at his usual place of employment with his Employer, and such usual place of employment is outside of his home, and if, when he so reports, he is able to perform all of the usual and customary duties of his occupation on a regular and full-time basis. An Employee shall be deemed Actively at Work on each day of a regularly paid vacation or on a regular non-working day on which he is not totally disabled, provided he was Actively at Work on the last preceding regular working day.

**ALCOHOLISM TREATMENT FACILITY:** A part of a Hospital devoted primarily to alcoholism treatment or a facility primarily established for alcoholism treatment and specifically licensed for that purpose by the jurisdiction in which it is located.

**AMBULATORY SURGICAL CENTER:** Any public or private establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous physician services and registered professional nursing services whenever a patient is in the facility, and which does not provide services or other accommodations for patients to stay overnight.

**ASSIGNMENT OF BENEFITS:** Authorization by the Employee for the Plan Supervisor to pay benefits directly to the provider of the service.

**BRAND NAME DRUG:** A “Brand Name Drug” may be a single-source drug, under patent protection. A “Brand Name Drug” may also be a multi-source drug when an equivalent Generic Drug exists. Caremark shall determine what is “Brand Name Drug”.

**CLOSE RELATIVE:** The spouse, parent, brother, sister, or child of the Covered Person, or the spouse of the Covered Person’s parent, brother, sister or child.

**COSMETIC SURGERY:** Surgery performed for the purpose of improving appearance rather than for restoring bodily function.

**COVERED PERSON:** The Employee or any person who is defined in this Plan as a Dependent of the Employee and is covered for benefits under this Plan.

**CUSTODIAL CARE:** The term “Custodial Care” means any type of service, including room and board and/or institutional service, which is designed essentially to assist a Covered Person, whether disabled or not, in the activities of daily living. Such services include assistance in walking or getting in and out of bed, bathing, dressing, feeding, preparation of special diets and supervision over medication which can normally be self-administered.

**DENTAL HYGIENIST:** Someone who is currently licensed to practice dental hygiene and is acting under the supervision and direction of a Dentist.

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

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

1. Is able to withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is not generally useful to a person in the absence of illness or Injury; and
4. Is covered under Medicare guidelines.
ELIGIBLE DEPENDENTS: The Eligible Employee's spouse, unless divorced or legally separated, and all unmarried children from birth to twenty-three (23) years of age, provided the children are unmarried, not employed on a regular, full-time basis and are fully dependent upon the Eligible Employee for financial support. The term "children" will include only natural children; stepchildren; legally adopted children (including children Placed with the adopting parents during the period before the adoption becomes final); or children permanently residing in the household of which the Employee is the head and actually being supported by the Employee within the meaning of the Internal Revenue Code (provided the Employee is related to the child by blood or marriage or is the child's legal guardian). For the purpose of this paragraph, the term "Placed" or "Placement" shall mean the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's Placement terminates upon the termination of such legal obligation. A child who is physically or mentally incapable of self-support upon attaining the age of twenty-three (23) may be considered a dependent while remaining incapacitated, unmarried and continuously covered under the Plan. To continue a child under this provision, proof of incapacity may be required from time to time.

ELIGIBLE EMPLOYEES: All Employees who work at least thirty (30) hours per week are eligible to be covered by the Plan. Employees who work less than thirty (30) hours per week and are in an exempted class are eligible to be covered by the Plan. Exempted class workers must be regularly scheduled to work in a position budgeted (or funded) for a minimum period of six (6) months in order to be eligible for benefits.

EMPLOYER: The Employer is the Ashland County-West Holmes Joint Vocational School District.

EXPERIMENTAL: The term Experimental means any treatment, procedure, facility, equipment, drugs, drug usage or supplies not yet recognized by the Plan and any of such items requiring Federal or other governmental agency approval not granted at the time services were rendered.

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

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

FULL-TIME STUDENT: A Dependent child who is enrolled in and regularly attending an accredited college or university for the minimum number of credit hours required by that college or university in order to maintain Full-Time Student status.

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

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

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

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

ILLNESS: A bodily disorder, disease, physical illness, mental infirmity, or functional nervous disorder of a Covered Person. A recurrent Illness will be considered one (1) Illness. Concurrent Illnesses will be considered one (1) Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one (1) Illness.

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

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

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

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

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

1. Performed due to definite symptoms of Illness or Injury; or
2. They reveal a need for treatment.
**MEDICARE**: All parts of Health Insurance for the Aged provided by Title XVIII of the Federal Social Security Act as now constituted or as hereafter amended.

**NAMED FIDUCIARY**: The Named Fiduciary is the Employer, which has the authority to control and manage the operation and administration of the Plan.

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

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

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

**PHYSICIAN**: A person duly licensed under the governing authority to perform the services rendered and covered for benefits under the Plan. Should such person be other than a Medical Doctor, Doctor of Osteopathy, or Doctor of Dental Surgery, the statutes of the applicable jurisdiction require that such person be recognized as a Physician to the extent that he is performing services within the scope of his license.

**PLAN ADMINISTRATOR**: The Plan Administrator is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. The Plan Administrator is named in the General Information section of the Plan document.

**PLAN SPONSOR**: The Plan Sponsor is the entity that sponsors this Plan. The Plan Sponsor is named in the General Information section of this plan document.

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

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

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

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

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

**TRUST**: The Trust is the Tri-County Trust.

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

**USUAL, CUSTOMARY, AND REASONABLE CHARGE (UCR)**: The UCR Charge for services is based on a relative value system for the types of services performed, taking into consideration the geographic areas where the services are performed, as well as the fees being charged within those geographic areas. The UCR Charge for supplies is based on a relative value system for the types of supplies provided, taking into consideration the geographic areas where the supplies are provided, as well as the fees being charged within those geographic areas. The calculation for UCR Charge takes into consideration any unusual circumstances or complications which require additional time, skill or experience in connection with the particular service or procedure.

**MEDICARE PROVISION**

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

For those Eligible Employees or Eligible Dependents who are entitled to benefits under Medicare because of total disability (and who are not or could not be entitled to benefits under Medicare on the basis of End Stage Renal Disease), Medicare benefits will be primary and this Plan will pay secondary benefits. For COBRA Qualified Beneficiaries who are entitled to benefits under Medicare because of total disability (and who are not or could not be entitled to benefits under Medicare on the basis of End Stage Renal Disease), this Plan will pay secondary benefits.
For the purpose of this paragraph, the time that a person is an Eligible Employee or Eligible Dependent is added to the time that a person is a COBRA Qualified Beneficiary to determine whether the Plan pays primary benefits or secondary benefits. For those Eligible Employees or Eligible Dependents who are entitled to benefits under Part A of Medicare solely on the basis of End Stage Renal Disease the following will apply:

For items and services furnished on or after August 5, 1997, with respect to Eligible Employees or Eligible Dependents who become entitled to benefits under Part A of Medicare on or after February 5, 1996. The Plan will pay primary benefits during the 30-month period beginning on the earlier of: the first month in which the Eligible Employee or Eligible Dependent becomes entitled to benefits under Part A of Medicare; or the first month in which the Eligible Employee or Eligible Dependent would have been entitled to benefits under Part A of Medicare if such person had filed an application for such benefits. After the expiration of such 30-month period, Medicare benefits will be primary and this Plan will pay secondary benefits (any charges which are not paid under this Plan should be submitted to Medicare).

Otherwise, the Plan will pay primary benefits during the 18-month period beginning on the earlier of: the first month in which the Eligible Employee or Eligible Dependent becomes entitled to benefits under Part A of Medicare; or the first month in which the Eligible Employee or Eligible Dependent would have been entitled to benefits under Part A of Medicare if such person had filed an application for such benefits. After the expiration of such 18-month period, Medicare benefits will be primary and this Plan will pay secondary benefits (any charges which are not paid under this Plan should be submitted to Medicare).

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

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

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

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

COORDINATION OF BENEFITS

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

When any person is eligible for coverage under two or more plans, it is necessary to determine which plan is primary and which plan is secondary. The following rules are used to determine the primary carrier.

1. A plan which does not have a non-duplication of benefits or coordination of benefits provision will be the primary carrier.
2. If all the plans have Coordination of Benefits provisions, a plan is primary if it covers the person as an employee, and secondary if it covers the person as a dependent.
3. The primary plan is the plan that covers the person as an active, full-time employee, or that employee's dependent.
   The secondary plan is the plan that covers that person in a status other than as an active, full-time employee, or that employee's dependent.
4. If a person is covered as a dependent child under more than one plan:
   a. the plan of the parent whose birthday falls earlier in the year is the primary plan;
   b. if the father and mother have the same birthday, the plan covering the parent longer is the primary plan;
   c. if the other plan's provisions for coordination of benefits does not follow the rule of this plan (as stated in 4a & b), then the rules for coordination of benefits of the other plan shall determine the order of benefits;
   d. if more than one plan covers a person as a dependent child of divorced or separated parents, benefits for the child will be determined by the specific terms of the Court decree. If the Court decree states which parent is responsible for the health care expenses of the child then that parent's plan shall be primary. If there is no Court decree or the Court decree is silent as to which parent is responsible for the health care expenses of the child then benefits will be determined by the specific terms of the Court decree.
expenses of the child, or if the Court decree is not being followed by the parent who is supposed to be
providing coverage, then the plan that will pay primary benefits will be determined in the following order:
(i) the plan of the parent with custody of the child;
(ii) the plan of the spouse of the parent with custody of the child;
(iii) the plan of the parent without custody of the child.

5. When the above rules do not establish an order of benefit determination, the benefits of a Plan which has covered
the person for the longer period of time shall be determined before the benefits of a Plan which has covered the
person the shorter period of time.

6. When this provision operates to reduce the total amount of benefits otherwise payable under this Plan as to a
person for any Claim Determination Period, each benefit that would be payable in the absence of this Coordination
of Benefits provision shall be reduced proportionately, and such reduced benefit shall be charged against any
applicable benefit limit of this Plan.

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

The term "Allowable Expense" means any necessary item of expense, the charge for which is Usual, Customary, and
Reasonable and is a covered expense under this Plan. When a Plan provides benefits in the form of services rather than cash
payments, then the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a
benefit paid.

The term "Claim Determination Period" means a calendar year or that portion of a calendar year during which the Covered
Person for whom claim is made has been covered under this Plan.

SUBROGATION

If any payments are made to or on behalf of a Covered Person and such payments arise as a result of an Injury, Illness or other
condition for which the Covered Person has, or may have, or asserts any claim or right of recovery (including, without limitation,
claims for pain and suffering, loss of consortium, consequential, punitive, exemplary or other damages) against a third party or
parties, then any payments made by the Plan for such medical expenses shall be made on the condition and with the agreement
and understanding that the Covered Person shall reimburse the Plan to the extent of (but not exceeding) any amount or amounts
recovered by or on behalf of the Covered Person (including the Covered Person’s estate) from any third party by way of
settlement or in satisfaction of any judgment relating to said claims. The Plan shall be entitled to reimbursement in full in
accordance with this paragraph irrespective of whether the Covered Person has been fully compensated for all or any of said
claims. As security for the Plan’s rights to such reimbursements, the Plan shall be subrogated to all claims, demands, actions or
rights of recovery of the Covered Person against any third party or parties (or their insurers) to the extent of any and all
payments made by the Plan; and any Covered Person that takes any action prejudicing or otherwise impairing the subrogation
rights of the Plan shall be liable to the Plan for any losses to the Plan caused by such action. Any action prejudicing or otherwise
impairing the subrogation rights of the Plan made by the Covered Person shall also terminate the Plan’s obligation to make
payments to or on behalf of the Covered Person. Each Covered Person agrees to execute and deliver all necessary
instruments, to furnish such information and assistance, and to take any action the Plan Administrator may require to facilitate
enforcement of its rights. The Plan shall withhold payments of claims made under this Plan, to the extent that the Plan has
reason to believe that said claims arise as a result of any act of a third party, until the Covered Person or Covered Person’s legal
representative executes a subrogation agreement.

The subrogation rights of the Plan as set forth in these paragraphs also apply to payments made by the Covered Person’s own
auto insurance (with the exception of payment for property damage).

For purposes of these paragraphs and any subrogation agreement executed pursuant hereto, the term Covered Person shall
include heirs, guardians, executors or other representatives of the Covered Person.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For purposes of determining the applicability of the Coordination of Benefits and Subrogation provisions of the Plan, or any
provision with a similar purpose of another plan, and implementing those provisions, the Plan may release necessary information
to, or obtain necessary information from, any other organization or person.

MEDICAL BENEFIT CONVERSION
An individual health policy is available for an Employee and/or his Dependents, whose coverage under this Plan ceases due to termination of employment, change in family status or loss of eligibility. The conversion policy will cover the Employee and/or his spouse and all Eligible Dependent children. The benefits provided under the new policy and the individuals to be covered will be determined by the rules of the insurer at the time the conversion application is received by the insurer. No evidence of insurability will be required. Written application and the first three (3) months' premium payments must be paid within thirty-one (31) days after the termination of group coverage. Information as to the coverage available and premium rates can be obtained at the time coverage terminates.

MISCELLANEOUS PROVISIONS

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION
Whenever payments have been made by the Plan in an amount which exceeds the maximum amount of payment allowed under the Plan at that time, the Plan shall have the right to recover such payment irrespective of to whom it was paid, to the extent of such excess from among one or more of the following parties: any persons to whom or with respect to whom such payments were made, any insurance companies, or any other organizations or persons.

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

RIGHTS OF RECOVERY
Whenever payments have been made by the Plan with respect to covered services in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Plan shall have the right to recover such payments to the extent of such excess from among one or more of the following, as the Plan shall determine: any persons to whom or with respect to whom such payments were made, any insurance companies, any other organizations or persons.

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

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

PLAN MODIFICATION AND AMENDMENT
The Plan Sponsor may modify or amend the Plan from time to time at its sole discretion and the amendments or modifications which affect the Plan Members will be communicated to them.

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

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

PROOF OF CLAIMS
Written proof of claims must be furnished to the Plan by or on behalf of the Covered Person or the provider within twelve months (12) after the date such claims are incurred (a claim shall be considered incurred on the date the service is rendered or the supply is received). Proof of claims includes the following:
- An itemized bill for the service or supply must be furnished to the Plan. An itemized bill for all professional services must include a diagnosis code (ICD 9 CM) and a CPT code (Current Procedural Terminology) for each service provided.
- The Eligible Employee must complete one (1) Employee Statement on a frequency to be determined by the Plan Administrator.
- If the Plan Administrator or Plan Supervisor requests information from the Eligible Employee, the Eligible Employee must furnish such information as requested.
- If the Plan Administrator or Plan Supervisor requests information from a provider and the provider does not furnish the requested information, the Eligible Employee will be required to obtain the requested information and furnish it to the Plan Administrator or Plan Supervisor.

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

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

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

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

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

PLAN IS NOT A CONTRACT
The Plan shall not be deemed to constitute a contract between the Plan Sponsor and any Employee/member or to be a consideration for, or an inducement or condition of, the employment of an Employee/member. Nothing in the Plan shall be deemed to give an Employee/member the right to be retained in the service of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any Employee/member at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the Plan Sponsor with the bargaining representatives of any Employee/members.

BOOKLETS
The Plan Sponsor has issued herewith to each Covered Employee/Member under this Plan an individual booklet which summarizes the benefits to which the person may be entitled, to whom benefits may be payable, and the provisions of the Plan principally affecting the Employee and his dependents.

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

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

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

MEDICAID PROVISION
Payments for benefits will be made in accordance with any assignment of rights made by or on behalf of a Covered Person as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of such Act as in effect on August 10, 1993. The fact that an Eligible Employee or Eligible Dependent is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act will not be taken into account for determining eligibility or determining or providing benefits under this Plan.

To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act and this Plan would provide a benefit for those items or services constituting such assistance, payment for benefits under this Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to the Covered Person to such payment for such items or services.

INDEPENDENT REVIEW PROVISIONS
Ohio Superintendent of Insurance Review of Plan Coverage
In the event that a Covered Person has been denied coverage of a health care service on the grounds that the service is not a service covered under the terms of the Plan, and the Covered Person has exhausted the Plan's appeal procedures, and the Covered Person has submitted a written request to the Ohio Superintendent of Insurance to review the denial, and the Ohio Superintendent of Insurance notifies the Plan that the service is a service covered under the terms of the Plan, then the Plan will cover such service.

If the Ohio Superintendent of Insurance notifies the Plan that making the determination requires the resolution of a medical issue, the Covered Person may request an external review of the denial in accordance with the “External Review of Medical Necessity” provision below or the “External Review for Terminal Illness” provision below.

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

A Covered Person (or the Covered Person’s parent, guardian, or other person authorized to act on behalf of the Covered Person with respect to health care decisions) may request an external review of medical necessity provided:
1. the request is in writing;
2. the Plan has denied, reduced, or terminated coverage for what would be a covered health care service except that the Plan has determined that the health care service is not Medically Necessary;
3. the proposed service, plus any ancillary services and follow-up care, will cost the Covered Person more than $500 if the proposed service is not covered by the Plan; and
A Covered Person need not be afforded an External Review of Medical Necessity if:

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

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

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

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

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

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

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

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

**External Review for Terminal Illness**

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

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

1. the request is in writing;
2. the Covered Person has a terminal condition that, according to the current diagnosis of the Covered Person’s Physician, has a high probability of causing death within two (2) years;
3. the Covered Person requests a review not later than sixty (60) days after receipt by the Covered Person of notice from the Ohio Superintendent of Insurance pursuant to the Ohio Superintendent of Insurance Review of Plan Coverage provision above, that making a determination requires the resolution of a medical issue;
4. the Covered Person’s Physician certifies that the Covered Person has a terminal condition that, according to the current diagnosis of the Covered Person’s Physician, has a high probability of causing death within two (2) years and any one of the following is applicable:
   a. standard therapies have not been effective in improving the condition of the Covered Person;
   b. standard therapies are not medically appropriate for the Covered Person; or
   c. there is no standard therapy covered by the Plan that is more beneficial than the therapy described in provision 5. below;
5. the Covered Person’s Physician has recommended a drug, device, procedure, or other therapy that the Physician certifies, in writing, is likely to be more beneficial to the Covered Person, in the Physician’s opinion, than standard therapies, or the Covered Person has requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition;
6. the Covered Person has been denied coverage by the Plan for a drug, device, procedure, or other therapy, recommended or requested pursuant to provision 5. above and has exhausted the Plan’s Appeal Procedures; and
7. the drug, device, procedure, or other therapy, for which coverage has been denied, would be covered under the Plan except for the Plan’s determination that the drug, device, procedure, or other therapy is Experimental or investigational.
In the event that a Covered Person’s Physician determines that a therapy would be significantly less effective if not promptly initiated, an expedited external review for terminal illness may be requested. A request for an expedited external review for terminal illness may be made orally or by electronic means provided that written confirmation of the request is submitted to the Plan not later than five (5) days after the request is made. The Covered Person’s provider must certify that the requested or recommended therapy would be less effective if not promptly initiated.

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

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

**How to Request an Expedited Review of Medical Necessity**

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

EXPEDITED REVIEW OF MEDICAL NECESSITY  
ASHLAND COUNTY-WEST HOLMES J.V.S.  
c/o Medillume III, Inc.  
1444 Hamilton Ave.  
Cleveland, OH 44114

Oral requests for an expedited review of medical necessity should be made by calling: (216) 377-7233.

Electronic requests for an expedited review of medical necessity should be addressed and sent as follows:

For fax transmissions:

EXPEDITED REVIEW OF MEDICAL NECESSITY  
ASHLAND COUNTY-WEST HOLMES J.V.S.  
c/o Medillume III, Inc.  
Via Fax Transmission  
and fax to (216) 575-5362.

**How to Request an Expedited Review for Terminal Illness**

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

EXPEDITED REVIEW FOR TERMINAL ILLNESS  
ASHLAND COUNTY-WEST HOLMES J.V.S.  
c/o Medillume III, Inc.  
1444 Hamilton Ave.  
Cleveland, OH 44114

Oral requests for an expedited review for terminal illness should be made by calling: (216) 377-7233.

Electronic requests for an expedited review for terminal illness should be addressed and sent as follows:

For fax transmissions:

EXPEDITED REVIEW FOR TERMINAL ILLNESS  
ASHLAND COUNTY-WEST HOLMES J.V.S.  
c/o Medillume III, Inc.  
Via Fax Transmission  
and fax to (216) 575-5362.

**HOW TO FILE A CLAIM**

* For medical claims, simply present your Plan identification card to the provider of service, and ask your provider to send the bill to the address shown on the ID card. Provider bills must include the appropriate diagnosis and procedure code information. If you are submitting bills instead of your provider, make sure you provide the following written information: the Employer’s name, the Eligible Employee’s name, and the Eligible Employee’s social security number.
* For dental claims, a completed dental claim form or an itemized bill from the Dentist's office will be accepted. If using a dental claim form, please complete Parts I and IV of the form and have your Dentist complete Parts II, III and V, then mail the completed form to the address printed on the form.

* Proof of claims must be submitted to Self-Funded Plans, Inc. within the time frame specified in the Proof of Claims provision outlined in this summary plan description.

HOW TO APPEAL A CLAIM

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

If a claim is denied in part or in full, you may appeal the decision. You or your authorized representative may examine pertinent documents (except for information in the file which the Physician does not wish made known to the claimant), and you may send a written letter of appeal outlining your position. The written appeal must be filed with the Plan Supervisor within sixty (60) days after denial is received; however, it is suggested that it be filed promptly whenever possible.

Upon receipt of the written appeal, the Plan Supervisor will furnish copies of all relevant documents to the Plan Administrator for review and final decision.

A decision will be made within sixty (60) days unless special circumstances require extension, in which case such decision will be rendered no later than 120 days. A letter will be sent to you which references the pertinent Plan provisions supporting the decision. Unless the “Independent Review Provisions” apply, this decision will be final.

GENERAL INFORMATION

1. **NAME OF PLAN:** The Ashland County-West Holmes Joint Vocational School District Medical, Prescription Drug, and Dental Benefits Plan
2. **NAME & ADDRESS OF PLAN SPONSOR:**
   Ashland County-West Holmes J.V.S.D.  
   OME-RESA  
   1783 State Route 60  
   Ashland, Ohio 44805
   Jefferson County Board of Education  
   2023 Sunset Boulevard  
   Steubenville, Ohio 43952
3. **EFFECTIVE DATE OF PLAN:** January 1, 1998
4. **PLAN SPONSOR IDENTIFICATION NUMBER:** 34-1429524
5. **PLAN NUMBER:** 501
6. **ACCOUNT NUMBER:** 506-471
7. **TYPE OF PLAN:** This is a welfare plan providing medical, prescription drug and dental benefits.
8. **TYPE OF ADMINISTRATION:** This is a self-insured plan.
9. **NAME, BUSINESS ADDRESS & TELEPHONE NUMBER OF THE PLAN ADMINISTRATOR:**
   Ashland County-West Holmes J.V.S.D.  
   1783 State Route 60  
   Ashland, Ohio 44805  
   (419) 289-3313
10. **NAME OF THE DESIGNATED AGENT FOR SERVICE OF LEGAL PROCESS & ADDRESS AT WHICH PROCESS MAY BE SERVED ON SUCH AGENT:**
    Same as above
11. **THE SOURCES OF CONTRIBUTION TO THE PLAN:**
    Employees will contribute toward the cost of employee and dependent coverage.
12. **THE DATE OF THE END OF THE YEAR FOR THE PURPOSES OF MAINTAINING THE PLAN'S FISCAL RECORDS:**
    Plan year ending May 31st of each year.