

JEFFERSON COUNTY
GOVERNMENT

EMPLOYEE
HEALTH
PLAN

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SCHEDULE OF MEDICAL BENEFITS

BENEFITS	PPO	NON-PPO
PRESCRIPTION DRUG BENEFIT (through Caremark)	Plan pays 75% of the drug cost (no deductible) with \$10 min per fill If Brand is purchased and Generic is available, Covered Person pays 25% plus the difference in cost between Generic and Brand	
MAIL ORDER DRUG BENEFIT (through Caremark Mail Service Pharmacy)	Plan pays 80% of the drug cost (no deductible) with \$5 minimum and \$25 maximum per fill. If Brand is purchased and Generic is available, Covered Person pays 20% plus the difference in cost between Generic and Brand	
PLAN YEAR DEDUCTIBLE (no cross application between PPO and non-PPO deductibles)		
Per Person	\$200	\$800
Per Family	\$400	\$1,600
BENEFIT PERCENTAGE PAYABLE	80%	50%
COINSURANCE MAXIMUM OUT-OF-POCKET PER PLAN YEAR (excluding deductible). No cross application between PPO and non-PPO Coinsurance Max Out-of-Pocket amounts)		
Per Person	\$1,000	\$4,000
Per Family	\$2,000	\$8,000
LIFETIME MAXIMUM BENEFIT	\$2,500,000	
AMBULANCE	80% after deductible	
SECOND SURGICAL OPINION BENEFIT	100%; deductible waived	
INPATIENT HOSPITAL	80% after deductible	50% after deductible
Co-Payment per Confinement	None	\$200
EMERGENCY ROOM for Emergency Care	80% after deductible	80% after deductible
Co-Payment per Visit (waived if admitted)	\$100	\$100
PHYSICIAN OFFICE VISIT (including specialists)	100%, deductible waived	50% after deductible
Co-Payment per Visit	\$20	None
SPEECH THERAPY (limited to max of 20 visits per plan year)	80% after deductible	50% after deductible
OUTPATIENT PHYSICAL THERAPY (maximum of 20 visits/Plan Year)	80% after deductible	50% after deductible
OUTPATIENT MENTAL/NERVOUS/SUBSTANCE ABUSE	80% after deductible	60% after deductible
Co-Payment per visit	\$20	\$20
VOLUNTARY STERILIZATION	80% after deductible	Not Covered
HOME HEALTH CARE	80% after deductible to max of 100 visits/plan year	Not Covered
TEMPOROMANDIBULAR JOINT DYSFUNCTION	80% after deductible	Not Covered
SKILLED NURSING FACILITY – max 100 days/plan yr	80% after deductible	50% after deductible
Co-Payment per admission	\$100	\$200
HOSPICE	80% after deductible	Not Covered
CHIROPRACTIC SERVICES (max 20 visits/plan yr)	80% after deductible	50% after deductible
Co-Payment per visit	\$20	None
WELL CHILD CARE	100% (deductible waived) to a maximum benefit of \$500 from birth to age 1 and \$150/plan yr from age 1 until age 9	Not Covered
Co-Payment per Visit	\$20	
ADULT PREVENTIVE CARE	100% (deductible waived) to a max of \$1,000/plan yr	Not Covered
Co-Payment per Visit	\$20	
SURGERY	80% after deductible	50% after deductible
DIAGNOSTIC X-RAY AND LAB	80% after deductible	50% after deductible
RADIOTHERAPY AND CHEMOTHERAPY	80% after deductible	50% after deductible
INHALATION THERAPY	80% after deductible	50% after deductible
CARDIAC REHABILITATION (max benefit of \$1,000/plan yr)	80% after deductible	50% after deductible
DURABLE MEDICAL EQUIPMENT	80% after deductible	50% after deductible
ROUTINE MAMMOGRAMS (max benefit per plan year of 130% of the lowest Medicare reimbursement rate in Ohio)	100% (deductible waived)	Not Covered
ANNUAL ROUTINE PAP SMEARS	100% (deductible waived)	Not Covered
Co-Payment per test	\$20	

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.

Effective February 1, 2011, the Maximum Lifetime Benefit shall be eliminated for Essential Health Benefits, and annual dollar limits that are currently in the Plan will be changed to \$750,000 for Essential Health Benefits for the period February 1, 2011 through January 31, 2012, to 1,250,000 for the period February 1, 2012 through January 31, 2013, and \$2,000,000 for the period February 1, 2013 through January 31, 2014. Effective February 1, 2014, annual dollar limits shall be eliminated for Essential Health Benefits.

SCHEDULE OF DENTAL BENEFITS

PLAN YEAR DEDUCTIBLE

TYPE I SERVICES	NONE
TYPE II, III AND ORTHODONTIC SERVICES*	\$50 PER PERSON \$100 PER FAMILY

BENEFIT PERCENTAGES

TYPE I SERVICES	100% OF REASONABLE CHARGE
TYPE II SERVICES	80% OF REASONABLE CHARGE
TYPE III SERVICES	80% OF REASONABLE CHARGE
ORTHODONTIC SERVICES*	60% OF REASONABLE CHARGE

MAXIMUM BENEFIT PAYABLE PER PLAN YEAR

TYPE I, II & III SERVICES COMBINED	\$1,500 PER PERSON
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MAXIMUM LIFETIME BENEFIT

ORTHODONTIC SERVICES*	\$1,000 PER PERSON
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* Orthodontic Services are only provided to Eligible Dependent children to age 18.

SCHEDULE OF VISION BENEFITS

VISION EXAMINATION	\$50
LENSES (Per Pair) and Frames	
SINGLE VISION	\$300
BIFOCALS	\$300
TRIFOCALS	\$300
CONTACT LENSES (Per Pair)*	
NECESSARY	\$300
COSMETIC	\$100

(Contact lenses can be allowed in lieu of lenses and frames)

* Note: the amount for a single lens is 50% of the amounts shown for a pair of lenses.

PRE-ADMISSION/POST-ADMISSION NOTIFICATION PROGRAM

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 by the next business day following the date of 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 provision.

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 Notification 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). 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.

PREFERRED PROVIDER PLAN

This Plan utilizes Medical Mutual of Ohio SuperMed Plus as its Preferred Provider Organization ("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. Medical Mutual of Ohio SuperMed Plus has agreements with Devon Health Services, Inc (in Pennsylvania) and 4Most (in West Virginia) to allow any provider who is a member of Devon or 4Most to be considered in-network for Medical Mutual of Ohio SuperMed Plus. 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. The payment rates vary between PPO Providers and non-PPO Providers, as described on the Schedule of Medical Benefits. Since PPO Providers have agreed to negotiated rates, Covered Persons will not be billed for amounts over the Reasonable and Customary Charge if they use PPO Providers. In the event that a Covered Person requires Emergency Care, the PPO level of benefits will apply to such charges, even if rendered by non-PPO Providers. If a Covered Person uses a Physician who is a PPO Provider and a Hospital that is a PPO Provider for a given procedure, any assistant surgeon, anesthesiologist, radiologist, and pathologist charges in connection with that procedure will be payable at the PPO level of benefits, even if rendered by non-PPO Providers. Charges for prescription drugs that are covered under the medical plan (and not the Prescription Drug or Mail Order Drug Benefit) will be payable as if these charges had been rendered by a PPO Provider. If a Covered Person is traveling or living outside of the PPO area and incurs medical expenses, such expenses will be payable at the PPO level of benefits.

PRESCRIPTION DRUG BENEFIT

The Prescription Drug Benefit covers Medically Necessary drugs which may be lawfully dispensed only upon the written prescription of a Physician. This benefit will cover up to the greater of a 34-day supply or quantity of 100. This benefit also covers Retin-A for Covered Persons through the age of 24 years, oral contraceptives, Seasonale, insulin needles and syringes, and injectable insulin. Each Covered Person will receive a CVS Caremark identification card. When a Covered Person presents the card to a member pharmacy, he need only pay the pharmacist his share of the coinsurance as shown in the Schedule of Medical Benefits for any prescription, filled or refilled. This drug coinsurance will not apply to the deductible or Coinsurance Maximum Out-of-Pocket amount. If a Physician prescribes a Brand Drug, and a Generic Drug is available, and the Covered Person chooses the Brand drug, then the Covered Person must pay his share of the coinsurance for the Brand Drug plus the difference in cost between the Brand Drug and the Generic Drug. If a Physician prescribes a Brand Drug, and a Generic Drug is not available, then the Covered Person will only need to pay his share of the coinsurance for the Brand Drug.

The Employer may choose to administer the prescription drug program on a reimbursement basis, without the use of CVS Caremark. If this is the case, the employee will submit drug expenses on a medical claim form and be reimbursed by the Plan for eligible prescription drug expenses at the rate shown in the Schedule of Medical Benefits.

The following charges are excluded under this benefit: anabolic steroids; contraceptives other than oral contraceptives or Seasonale; anorectics (any drug used for the purpose of weight loss); anti-wrinkle agents (e.g. Renova), regardless of intended use; growth hormones; hair removal products; immunization agents; blood or blood plasma; infertility drugs; minoxidil (e.g. Rogaine) for the treatment of alopecia; pigmenting/depigmenting agents; Retin-A for Covered Persons age 25 and older; smoking deterrent or cessation aids; therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use (other than as specified herein); vitamins (including prescription vitamins); charges for the administration or injection of any drug; drugs labeled "Caution - limited by federal law to investigational use," or Experimental/Investigational drugs, even though a charge is made to the Covered Person; and medication which is to be taken by or administered to a Covered Person, in whole or in part, while he is a patient in a licensed Hospital, rest home, sanitarium, Convalescent Facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

MAIL ORDER DRUG BENEFIT

The Mail Order Drug Benefit will be administered by CVS Caremark Mail Service Pharmacy. This benefit covers a ninety- (90) day supply of many maintenance medications, based on the benefit payable that is specified in the Schedule of Medical Benefits. The drugs that are excluded in the Prescription Drug Benefit are also excluded in the Mail Order Drug Benefit. When a Covered Person purchases Mail Order Drugs, he need only pay his share of the coinsurance as shown in the Schedule of Medical Benefits for any prescription, filled or refilled. This drug coinsurance will not apply to the deductible or Coinsurance Maximum Out-of-Pocket amount.

MEDICAL EXPENSE BENEFITS

Coinsurance Maximum Out-of-Pocket

The Coinsurance Maximum Out-of-Pocket amount that is specified in the Schedule of Medical Benefits refers to the maximum amount any Covered Person or covered family will have to pay in any Plan Year in coinsurance. Once this amount has been met, the remainder of benefits for that Plan Year will be payable at 100%. The Coinsurance Maximum Out-of-Pocket amount does not include the deductible, co-payments, penalties, or charges that are excluded or that exceed limits outlined in this Plan. PPO and non-PPO Coinsurance Maximum Out-of-Pocket amounts shall not be applied toward each other.

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 Medical Benefits. The deductible applies only once during any Plan Year, even though a person may have several different accidents or illnesses. PPO and non-PPO deductibles amounts shall be applied toward each other.

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 Medical Benefits, no further deductible will be required for any other member of the family for the balance of that Plan Year.

Eligible Expenses

The following services and supplies are 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 care 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. Emergency room benefits for Emergency Care are as described in the Schedule of Medical Benefits. If care is received in a room that does not meet the definition of Emergency Care, benefits will be payable at the regular percentage rates based on if a PPO or non-PPO provider is used. In addition, a penalty of 50% of the charge will be applied to the emergency room bill. This penalty will not apply toward the deductible or Coinsurance Maximum Out-of-Pocket.
2. Physicians' charges for treatment of an illness or injury (including charges for an elective sterilization rendered by a PPO provider for an Eligible Employee or Eligible Employee's spouse only [this includes the Essure procedure]). 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. Physician office visits are payable as specified in the Schedule of Medical Benefits. Office visits are visits to a Physician where an evaluation or

treatment is rendered. The Physician Office Visit benefit will include charges for both an office visit and diagnostic testing relating to hearing testing, provided such services are rendered by a PPO provider (such services are payable at 100% subject to the per visit co-payment outlined in the Schedule of Medical Benefits). Physician charges for a second surgical opinion are payable as specified in the Schedule of Medical Benefits. For this benefit to be payable, the Physician who is being consulted shall be a board certified surgeon in the appropriate specialty, shall not be affiliated in any way with the Physician who will be performing the actual surgery, and shall not assist with the surgery.

3. Charges for diagnostic x-ray and laboratory examinations.
4. Charges for chemotherapy and x-ray, radium and radioactive isotope therapy.
5. Charges for medical appliances, crutches, dressings, and other equipment.
6. Charges for anesthesia and the administration thereof.
7. Charges for blood and blood plasma, to the extent it is not donated or otherwise replaced.
8. Charges for the rental of Durable Medical Equipment under a lease acceptable to the Plan. The Plan may, in its discretion, authorize purchase of such equipment.
9. Charges for physical therapy prescribed by the attending Physician as to type and duration when performed by a licensed physical therapist.
10. Charges for occupational therapy prescribed by the attending Physician as to type and duration when performed by a licensed occupational therapist (however, charges incurred for supplies used in connection with occupational therapy are not covered).
11. Charges for orthopedic braces (except corrective shoes) and prosthetic appliances (including replacements required as a result of the Covered Person's natural growth and development).
12. 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. No other charges for transportation or travel will be covered.
13. Charges for a Physician's or speech therapist's fees for restoratory or rehabilitary 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.
14. Charges for maternity. Covered charges include obstetrical services, prenatal and postnatal care. 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 Hospital and Physician charges for Medically Necessary and/or routine care for the newborn well baby while the baby is in the Hospital. The Plan also covers charges for the baby's circumcision.
15. Charges for care rendered by a Hospice. Such care is only covered if rendered by a PPO provider. 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.
16. Charges for care in a Skilled Nursing Facility if a Physician determines that the Covered Person requires skilled nursing care. This benefit is limited to the maximum number of days per Plan Year that is specified in the Schedule of Medical Benefits. Admission to the Skilled Nursing Facility must be within seven (7) days of an acute care Hospital confinement of not less than three (3) days, and the admission to the Skilled Nursing Facility must be for the same or related condition as the Hospital confinement.
17. Charges for home care visits rendered through a Home Health Care Agency, provided the Physician certifies the medical necessity of home health care. This benefit is only provided to PPO Providers, and it is limited to the maximum number of days per Plan Year that is specified in the Schedule of Medical Benefits. 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. For the purposes of determining the visits limitation, a visit is a personal contact in the Covered Person's home made for the purpose of providing a covered service by a health worker on the staff of a home care agency or by others under contract or arrangements made with such agency. However, if a service lasts more than four (4) consecutive hours, each four (4) hour segment or part of a segment will be counted as one (1) visit. 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.
18. 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 recipient.
 - b. If both the donor and the recipient are covered under this Plan, eligible medical expenses incurred by each person will be considered as the recipient's charge.

- 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.
19. Charges for the following when a Covered Person is receiving benefits in connection with a mastectomy and elects breast reconstruction in connection with such mastectomy:
 - a. reconstruction of the breast on which the mastectomy has been performed;
 - b. surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - c. treatment of physical complications of all stages of mastectomy, including lymphedemas; and
 - d. prostheses.
 in a manner determined in consultation with the attending Physician and such Covered Person.
 20. 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 (if any) outlined in the Plan for such drug addiction treatment.
 21. Charges for well-child care, including routine office visits, appropriate immunizations, and laboratory tests that are not treating an Illness or Injury. Such care is only covered if rendered by a PPO provider. The benefit payable for such care is specified in the Schedule of Medical Benefits. No well-child care benefits are provided after age nine (9).
 22. Charges for preventive care for Eligible Employees and their eligible spouses care, including routine office visits, appropriate immunizations, mammograms, PSA tests, routine colonoscopy testing, HPV testing for cervical cancer and x-ray and laboratory tests that are not treating an Illness or Injury. Also included are HPV vaccines for female employees and Eligible Dependent spouses and children. Such care is only covered if rendered by a PPO provider. The benefit payable for such care is specified in the Schedule of Medical Benefits.
 23. Charges for one (1) routine pap test per Plan Year for all Covered Persons, regardless of age. Such care is only covered if rendered by a PPO provider.
 24. Charges for routine mammograms for Covered Persons age 35 and older, limited to the maximum benefit per Plan Year that is specified in the Schedule of Medical Benefits. Any amounts that exceed this maximum can be payable under the preventive care benefit described in item 22. This procedure is only covered if rendered by a PPO provider.
 25. 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. Such care is only covered if rendered by a PPO provider.
 26. Charges for oxygen and the administration thereof.
 27. 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 nurse who ordinarily resides in the Covered Person's home, or is a Close Relative.
 28. Charges by a licensed pharmacist or Physician for such drugs and medicines which can be purchased only upon a Physician's prescription (other than those drugs that are excluded herein and other than those drugs that are covered under the Prescription Drug Benefit or the Mail Order Drug Benefit). The drugs covered under the medical plan will be payable at the PPO level of benefits.
 29. Charges for care rendered in an Alcoholism Treatment Facility (payable as if such charges were incurred in a Hospital).
 30. Charges for care rendered in an Ambulatory Surgical Center.
 31. Charges for care rendered in an Urgent Care Facility.
 32. Charges for a Hospital Outpatient department cardiac rehabilitation program, limited to the maximum benefit specified in the Schedule of Medical Benefits. This benefit will only be payable if all of the following conditions have been met:
 - a. the person has had myocardial infarction, coronary bypass surgery, stable angina pectoris, angioplasty, or a heart transplant;
 - b. the person starts his cardiac rehabilitation program within twelve (12) months after discharge from the Hospital; and
 - c. the cardiac rehabilitation program is rendered in the Hospital's Outpatient department or in a Medicare-approved facility for cardiac rehabilitation.
 33. Charges for inhalation therapy.
 34. Charges for hearing aids supplied by PPO providers only, including replacements but not including repairs and replacement batteries.
 35. Charges for Enteral Formulae, which is a liquid source of nutrition administered under the direction of a Physician, which may contain some or all the nutrients necessary to meet minimum daily nutritional requirements, and is administered into the gastrointestinal tract through a tube. Coverage is provided for Enteral Formulae when administered on an Outpatient basis, primarily for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary metabolic disorders. Coverage is also provided for Enteral Formulae when administered on an Outpatient basis, when Medically Necessary for a medical condition, when considered to be the sole source of nutrition and when provided through a feeding tube and utilized instead of regular shelf food or infant formulas. Once it is determined that a Covered Person meets these criteria, coverage will continue as long as the Formulae represents at least 50% of the daily caloric requirement. The following are excluded under this benefit: blenderized food, baby food, or regular shelf food when used with an enteral system; milk or soy based infant formulae with intact proteins; any formulae, when used for convenience; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance; the following formulae when provided orally: semi-synthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; and normal food products used in the dietary management of rare hereditary genetic metabolic disorders.
 36. Charges for one wig coincident with or following chemotherapy, to a maximum benefit of \$200 per lifetime.
 37. This Plan is in compliance with Ohio and federal mental health parity laws.

MAXIMUM BENEFIT

The Maximum Lifetime Benefit payable per person is specified in the Schedule of Medical Benefits. The Maximum Lifetime Benefit applies only to charges incurred while the person is covered under this Plan.

PRE-EXISTING CONDITION LIMITATION

A Pre-Existing Condition is any Injury or medical condition for which medical advice, diagnosis, care, and/or treatment was recommended to or received by a Covered Person during the six (6) month period ending on the Enrollment Date. In the event of a Pre-Existing Condition, benefits will not be payable for the Pre-Existing Condition until the earliest of one of the following occurs:

1. A period of twelve (12) months (eighteen [18] months in the case of a Late Enrollee) has elapsed since the Covered Person's Enrollment Date; or
2. Evidence of Creditable Coverage has been presented to the Plan proving that the Covered Person had Creditable Coverage for a period of at least twelve (12) months (eighteen [18] months in the case of a Late Enrollee) determined as of the Enrollment Date and the Eligible Employee or Eligible Dependent has not had a Significant Break in Coverage; or
3. Evidence of Creditable Coverage has been presented to the Plan proving that the Covered Person had Creditable Coverage for a certain number of days, determined as of the Enrollment Date and the Covered Person has not had a Significant Break in Coverage, and when those certain number of days are added to the number of days that have passed since the Enrollment Date, a period of at least twelve (12) months (eighteen [18] months in the case of a Late Enrollee) has elapsed.

The Pre-Existing Condition Limitation will not apply to an Eligible Dependent, who as of the last day of the thirty (30) day period beginning on the date of his birth, has Creditable Coverage and evidence of such Creditable Coverage has been presented to the Plan and he has not had a Significant Break in Coverage. The Pre-Existing Condition Limitation will not apply to an Eligible Dependent who is adopted or Placed for adoption before attaining the age of eighteen (18) and who as of the last day of the thirty (30) day period beginning on the date of his adoption or Placement for adoption, has Creditable Coverage and evidence of such Creditable Coverage has been presented to the Plan and he has not had a Significant Break in Coverage. The Pre-Existing Condition Limitation will not apply to pregnancy. 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. Effective February 1, 2011, the Pre-Existing Condition Limitation shall not apply to Covered Persons who are younger than age 19. Effective February 1, 2014, the Pre-Existing Condition Limitation shall not apply to any Covered Persons.

MEDICAL PLAN LIMITATIONS AND EXCLUSIONS

The following charges are limited or excluded under the Plan:

1. Charges for the reversal of an elective sterilization or charges that result from complications from that procedure.
2. Charges for services or supplies that cannot be reasonably expected to contribute to the improvement of the patient's condition, illness or injury.
3. Charges incurred in connection with eye refractions, the purchase or fitting of eyeglasses, contact lenses, or such similar aid devices. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery..
4. Charges for dental care (unless such treatment is rendered as a result of and within one year following an accidental Injury sustained while covered under the Employer's Plan, or unless such treatment is for the excision of bony impacted, unerupted teeth, or for the excision of a tumor or cysts, or the incision and drainage of an abscess or cyst). In addition, if it is Medically Necessary that a Covered Person be treated at a Hospital for a dental condition, the Hospital charges will be a covered expense.
5. Charges for Custodial Care.
6. 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.
7. Charges for personal services not required in the diagnosis or treatment of an Illness or Injury, including but not limited to TV, telephone, guest trays, guest beds, reading materials, and other guest-related requests.
8. Charges for Cosmetic Surgery unless required because of an accidental Injury which occurs while covered under the Employer's Plan; because of a congenital malformation of a dependent child; due to replacement of diseased tissue which has been surgically removed; or as specified herein.
9. Charges for 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.
10. Charges for services which are not Medically Necessary (except as specified herein) or which have not been recommended by a Physician
11. Charges which are in excess of the Reasonable and Customary Charge.
12. Charges for Preventive/Maintenance Care, routine physical examinations, and immunizations (except as specified herein).
13. Charges for vitamins, minerals or dietary supplements.
14. Charges for sex transformation and hormones related to such treatment and charges for related psychiatric care.
15. Charges for recreational or educational therapy, including biofeedback training.
16. Charges for marital counseling.
17. Charges for hair replacement, transplants or stimulants.
18. Charges incurred in connection with any treatment, therapy, teaching technique or program for remedial education or rehabilitative or rehabilitative training which is principally intended to overcome, ameliorate or compensate for any learning impairment whatsoever, regardless of whether such impairment is diagnosed as functional or organic.

19. Charges for enrollment in a health, athletic, or similar club; for a non-smoking or similar program; or for any treatment of obesity including diet control or diet supplements, except for surgical treatment of morbid obesity which is determined to be in excess of 70% of standard weight tables (such treatment is only covered if the morbid obesity is determined as secondary diagnosis to an otherwise life-threatening condition).
20. Charges for any surgical procedure for the correction of a visual refractive problem.
21. Charges for vision therapy and any related diagnostic testing.
22. 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.
23. Charges for artificial methods of conception (including but not limited to in-vitro or in-vivo fertilization, artificial insemination, surrogate parenting procedures, embryonic transplant, GIFT or ZIFT) and related tests; or fertility drugs.
24. Charges for contraceptives other than those specifically shown as covered under the Prescription Drug Benefit.
25. Charges for any service which is due or related to complications arising from treatment of services otherwise excluded.
26. Charges which were incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.
27. Charges for enteral/supplemental feedings purchased as over-the-counter supplements.
28. Charges for hypnosis, acupuncture, or other alternative medical treatments.
29. Charges for follow-up care in an emergency room.
30. Charges for counseling for borderline intellectual functioning or developmental disorders.
31. Charges incurred in connection with travel expenses of a Covered Person (other than as specified herein) or a provider.
32. Charges for any services or supplies incurred in connection with treatment of nicotine addiction.
33. Charges for an elective abortion. Charges for an elective abortion will be a covered expense where the life of the mother would be endangered if the fetus were carried to term. If medical complications have arisen from an abortion, charges for treatment of those complications will also be covered expenses.
34. Charges for care or treatment of an Injury or Illness arising out of the course of any employment or occupation for wages or profit, or for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease law, whether or not any coverage for such benefits is actually in force.
35. 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 for Inpatient care in a military Hospital for military retirees, dependents of retirees and dependents of active military personnel.
36. Charges resulting from any intentionally self-inflicted Injury or Illness, unless due to domestic violence or a medical condition; and charges for Illness or Injury caused by or contributed to by engaging in an illegal occupation or by committing or attempting to commit a felony or assault.
37. 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, or due to participation in a riot.
38. 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.
39. Charges for appointments not kept, or for the completion of claim forms.
40. Charges for Experimental or Investigational procedures.
41. Charges for room and board incurred in connection with a Hospital admittance on Friday, Saturday, or holiday unless significant medical treatment is given on those days; significant medical treatment includes any treatment not normally connected with room, board or general nursing services.
42. 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.
43. Charges for purchase or rental of escalators, elevators, saunas, steambaths, swimming pools, or blood pressure kits.
44. Charges for materials used in occupational therapy.
45. Charges for services which are not performed according to accepted standards of medical practice for the condition being treated.
46. Charges for procedures, services, supplies and prescription drugs related to sexual dysfunction, including but not limited to penile implants.

DENTAL EXPENSE BENEFITS

Amount Payable

Benefits are payable for each type of service after the deductible (if any) for that type of service 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 Type II, Type III and Orthodontic Services are payable. The deductible applies only once each Plan Year.

Family Deductible

If, in any Plan 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 Plan Year.

Three Month Carryover Deductible

Any dental expenses incurred during the last three (3) months of a Plan Year which apply toward the deductible for that year will also be applied toward the deductible for the next Plan Year.

Maximum Benefit

The maximum benefit payable for each person in any Plan Year for Type 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 Plan, 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. Benefits paid for temporary service will be deducted from the benefits otherwise payable for the final service.

Alternate Treatment

If alternate services or supplies may be employed to treat a dental condition, Covered Dental Expenses will be limited to the Reasonable and Customary 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 Reasonable and Customary 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 appropriate and meet professionally recognized national standards of quality; and 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; however, expenses that are incurred for the performance of any dental service not listed below will be considered a Covered Dental Expense only if the Plan Administrator agrees in writing to accept such expenses as Covered Dental Expenses. If the Plan Administrator so agrees, the benefits that are payable will be consistent with a payment for such similar Covered Dental Expenses that would provide the least costly professionally adequate treatment.

Type I Services

1. Routine oral exams, but not more than two (2) examinations in any Plan Year.
2. Prophylaxis, but not more than two (2) prophylaxis treatments in any Plan Year.
3. X-rays. Supplementary bitewing x-rays are covered twice per Plan Year. Full-mouth ex-rays are covered once in any period of 36 consecutive months.
4. Topical application of sodium or stannous fluoride, but only if the covered family member has not yet attained the age of fifteen (15) years. Such charges will be covered up to twice in a Plan Year.
5. Emergency pain treatments.
6. Space maintainers for Covered Persons under age nineteen. All adjustments within six (6) consecutive months of installation are covered.
7. Tests and laboratory examinations including bacteriologic cultures, pulp vitality tests and diagnostic casts (study models).

Type II Services

1. Oral surgery (excluding any charges which are covered under the medical benefits plan).
2. Extractions.
3. Alveoplasty (surgical preparation of ridge for dentures) and tooth replantation.
4. Fillings (amalgam, acrylic, composite, synthetic porcelain and silicate).
5. General anesthetics administered in connection with oral surgery, only if Medically Necessary.
6. Endodontic treatment, including root canal therapy.
7. Injections of antibiotic drugs and application of desensitizing medication by the attending Dentist.
8. Repair or recementing of crowns, inlays, onlays, bridgework or dentures, or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, not to exceed one relining or rebasing in any period of 36 consecutive months.
9. Gingivectomy and osseous surgery and treatment of periodontal and other diseases of the gums and tissues of the mouth.

Type III Services

1. Inlays, onlays, gold fillings or crowns, but only when the tooth cannot be restored to proper function with an amalgam, silicate, acrylic, synthetic porcelain or composite filling.
2. Initial installation of removal partial, fixed partial or complete dentures (including adjustments for the six [6] month period following installation).
3. Initial installation of fixed bridgework (including inlays and crowns to form abutments).
4. Replacement of existing dentures or bridgework, but only when:
 - a. the existing denture/bridge cannot be repaired and made serviceable;
 - b. the existing denture/bridge, if installed while covered under the Employer's Plan, is at least five (5) years old; or
 - c. the existing denture is an immediate temporary denture which must be replaced by a permanent denture within one (1) year.

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. Orthodontic Services are only provided for Eligible Dependent children to age 18. Related oral examinations, surgery and extractions are included.

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. 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 a least four 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 tooth section (one cusp); or
 - c. cross-bite; or
 - d. control harmful habits.

Orthodontic benefits will be paid in equal installments. The Covered Person must be covered on the first day of each installment period in order to receive payment for that period. The first installment 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 or stolen prosthetic device.
5. Charges for sealants, for oral hygiene instructions or dietary instruction, 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 (other than as specified herein).
7. Charges for services or supplies which are furnished prior to the effective date of coverage or after coverage has terminated. 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 years following the date of its original installation unless such replacement is made necessary by the placement of any 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 adjustment or repair to a denture performed within six (6) months of the installation of the denture.
10. Charges for implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants.
11. Charges for periodontal splinting of teeth except for treatment of trauma.
12. Charges for facings on pontics or crowns posterior to the second bicuspid.
13. Charges for any spare, duplicate or replacement device other than as allowed herein.
14. Charges incurred for any treatment of temporomandibular joint (TMJ) disturbances.
15. Charges for care or treatment of an Injury or Illness arising out of the course of any employment or occupation for wages or profit, or for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease law, whether or not any coverage for such benefits is actually in force.

16. 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 not benefits.
17. Charges for dental care resulting from any Injury sustained as a result of war, declared or undeclared.
18. 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.
19. Charges for appointments not kept, or for the completion of claim forms.
20. Charges which are in excess of the Reasonable and Customary Charge.
21. Charges, if any that are included as covered medical expenses.
22. Charges for dental care not included in the list of defined eligible expenses.
23. Charges made by a Dentist or Dental Hygienist who normally lives in the Covered Person's home, or is a Close Relative.

VISION EXPENSE BENEFITS

Vision Expense Benefits are payable based on the maximum benefits shown in the Schedule of Vision Benefits.

Time Period of Benefits

Vision examinations are covered once every twelve (12) months. Frames and lenses are limited to one complete set every twelve (12) month period. The time period will begin on the date on which the last payment of benefits for each item was made under this plan of benefits. Benefits for contact lenses will be in lieu of all other frames and lenses for the same benefit period.

Contact Lenses

Contact Lenses will be considered as necessary under the following circumstances:

1. If visual acuity is not correctable to 20/70 in the better eye, except by the use of contact lenses; or
2. If the patient is being treated for a condition, such as Keratoconus, or Anisometropia, and contact lenses are customarily used as part of the treatment; or
3. If required following cataract surgery.

Covered Vision Expenses

Vision exams include a complete analysis of the vision functions, including the prescription of lenses where indicated. Lenses include all lens material including tints, plastic multi-focal lenses and oversized lenses.

Vision Plan Limitations and Exclusions

There is no coverage for services and supplies for any of the following charges:

1. Charges for orthoptics, vision training, subnormal vision aids, aniseikonic lenses or plano lenses.
2. Charges for medical or surgical treatment of the eyes.
3. Charges for services and supplies not listed as a covered item.
4. Charges for sunglasses, frames for sunglasses, or safety lenses or goggles.
5. Charges for frames or lenses not needed to correct abnormal vision.
6. Charges for services or supplies which are furnished prior to the effective date of coverage or after coverage has terminated.
7. Charges for care or treatment of an Injury or Illness arising out of the course of any employment or occupation for wages or profit, or for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease law, whether or not any coverage for such benefits is actually in force.
8. Charges for services provided or paid for by any government or its agencies.
9. 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.
10. 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.
11. Charges for appointments not kept, or for the completion of claim forms.
12. Charges for lost or stolen lenses and frames.
13. Lenses and frames furnished under this Plan which are lost or broken will not be replaced, except at the normal intervals when services are otherwise available.
14. Charges for services rendered by a Close Relative.
15. Charges which are covered under the Medical Benefits plan.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

New Eligible Employees who are enrolled will be covered on the first day of the month coinciding with or next following the date they have satisfied the Waiting Period.

Eligible Employees who choose to join the HMO option will be covered for dental and vision benefits under this Plan.

Eligible Employees who are rehired within the six (6) month period following the date of termination of coverage will be covered on the date they return to work (the Pre-Existing Condition Limitation will apply to such Eligible Employees and their Eligible Dependents). If an Eligible Employee transfers from part-time to full-time status at any time during the month, his coverage shall begin on the first day of the month coinciding with or next following the date of the transfer, as long as the Waiting Period has been satisfied. 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.

Coverage must be in effect for an Eligible Employee in order for coverage to take effect for an Eligible Dependent.

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 Eligible Employee already has dependent coverage; however, the newborn must be properly enrolled into the Plan as a new dependent within one (1) year following the date of birth. Claims submitted for a newborn will not be processed until the newborn is properly enrolled. If the Eligible Employee does not have dependent coverage at the time of the birth, the newborn must be properly enrolled into the Plan within thirty-one (31) days from the date of birth. 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 thirty-one (31) 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. 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.

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.

If both husband and wife are employed by the Employer, the husband or wife whose birth date falls earlier in the calendar year will be covered as an Eligible Employee and may include his or her spouse as an Eligible Dependent along with any eligible dependent children. No one can be covered under this Plan as both an Eligible Employee and Eligible Dependent. Premium funding will be taken from the department of the primary covered employee.

If two Eligible Employees are married to each other, and one is covered as an Eligible Dependent of the other, if the Eligible Employee who is carrying the dependent coverage terminates, coverage can be transferred to the Eligible Dependent who is still an Eligible Employee, and no additional waiting period or new pre-existing condition limitation will apply, provided coverage is continuous. Credit will be given toward maximums, deductible, etc.

An Eligible Employee who wishes to enroll for employee or dependent coverage more than thirty-one (31) days after the Eligible Employee or Eligible Dependent is eligible for coverage may do so only during the month of December of any year; such coverage will become effective on the next following February 1st. An Eligible Employee who wishes to change medical plan options from the HMO option to this Plan, or vice-versa, must make the election during the month of December of any year; such coverage will become effective on the next following February 1st.

A person is eligible to enroll in the Plan if (1) the employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the employee requests coverage under the plan within 60 days after the termination, or (2) the employee or dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the plan within 60 days. Such coverage will be effective on the day following the date coverage is lost under Medicaid or CHIP.

In addition to the annual open enrollment period, an Eligible Employee may enroll (or re-enroll) for employee or dependent coverage if he originally declines coverage for himself or his Eligible Dependents because of other medical coverage in force at the time, and that other medical coverage is either lost or the employer contributions for such other coverage ceases. The enrollment must take place within thirty-one (31) days following the loss of other coverage or the ceasing of employer contributions for the other coverage, and coverage under this Plan will be effective on the day following loss of other coverage or ceasing of employer contributions for the other coverage. However, in the case of other coverage through COBRA, an Eligible Employee or Eligible Dependent is only entitled to enroll after the COBRA continuation period is exhausted. If the other health coverage is lost due to the Eligible Employee's or his dependent's failure to pay contributions, premiums, or for causes such as filing a fraudulent claim, the Eligible Employee may not enroll for Eligible Employee and/or Eligible Dependent coverage under this provision.

An Eligible Dependent who loses Eligible Dependent status because he is no longer a Full-Time Student may have coverage reinstated upon becoming a Full-Time Student and meeting all other requirements of an Eligible Dependent. Such Eligible Dependent's coverage will be reinstated on the date that such Eligible Dependent is once again a Full-Time Student.

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 and 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 under the Plan shall not be imposed in connection with the reinstatement of such coverage upon reemployment under the USERRA if that exclusion 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. In the event of layoff or termination, coverage will terminate on the last day of the month for which premiums have been paid;
3. In the event of Employer approved leave of absence, coverage will continue for up to three (3) months following the date such leave of absence begins, subject to the payment of any required contribution on the part of the Eligible Employee. COBRA eligibility would start at the end of the three (3) month period.
4. In the event an Eligible Employee is unable to work as a result of an Injury or Illness arising out of employment with the Employer, and who has filed a claim for and is receiving benefits pursuant to the Ohio Workers' Compensation Act and its amendments, will be eligible to continue these benefits for up to a maximum of six (6) months. In the event such Eligible Employee is unable to return to work by the end of this six (6) month period, the Employer will contribute one-half (1/2) of the cost of coverage with the Eligible Employee contributing the other half (1/2) of the cost of such coverage, for an additional six months. Any person qualified for these continuations must submit their portion of the monthly premium to the Auditor's office no later than the fifteenth (15th) of the month for which the premiums apply;
5. The date all coverage or certain benefits are terminated on a particular class by modification of the Plan;
6. The date the Employee fails to make any required contribution for coverage; or
7. 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.

MICHELLE'S LAW

If a child qualifies as an Eligible Dependent due to being a Full-Time Student, and such child is forced to take a Medically Necessary Leave of Absence from school due to a serious Illness or Injury, coverage can be continued for such Eligible Dependent. A "Medically Necessary Leave of Absence" is defined as a leave of absence from a post-secondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965) or any other change in enrollment at such an institution that begins while the student is suffering from a serious Illness or Injury; is Medically Necessary; and causes the student to lose student status for purposes of coverage under the terms of the Plan. Coverage will be continued until one year after the first day of the leave of absence or the date coverage would otherwise terminate under the terms of the Plan, whichever comes first. The Plan must receive a written certification by the treating Physician of the dependent child which states that the child is suffering from a serious Illness or Injury and that the leave of absence is Medically Necessary. The child taking the leave described herein is entitled to the same benefits as if the child had continued to be covered as a student who did not take leave. This Plan provides no greater rights than what Michelle's Law requires (nothing in this Plan is intended to expand the rights of any participant beyond the law's requirements). If Michelle's Law is amended, this Plan will follow such legislation.

THE FAMILY AND MEDICAL LEAVE ACT OF 1993

In the event that the Employer approves a leave under The Family and Medical Leave Act of 1993 (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 or up to 26 weeks of service member family caregiver leave (provided that required contributions, if any, are made by or on behalf of that Eligible Employee). Such persons will continue to be covered under the Plan as if there had been no break in service. 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 earlier 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.

This provision shall include all revisions made to the FMLA regulations.

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). The COBRA provision shall be modified to be in compliance with the American Recovery and Reinvestment Act of 2009 (ARRA).

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 Eligible Employee must become ineligible for group coverage because of a Qualifying Event consisting of a termination of the Eligible 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 Eligible 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;
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 **Deputy Auditor** 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

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 Eligible Employee for the Plan Supervisor to pay benefits directly to the provider of the service.

BRAND DRUG: A non-Generic 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 Eligible Employee or any person who is defined in this Plan as an Eligible Dependent of the Eligible Employee and is covered for benefits under this Plan.

CREDITABLE COVERAGE: Coverage of an Eligible Employee or Eligible Dependent under any of the following:

1. A group health plan that is an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.
2. Health insurance coverage that consists of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.
3. Part A or B of Title XVIII of the Social Security Act (Medicare).
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).
5. Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, uniformed services means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service Act).
6. A medical care program of the Indian Health Service of a tribal organization.
7. A State health benefits risk pool. For purposes of this section, a State health benefits risk pool means a) an organization qualifying under section 501 (c)(26) of the Internal Revenue Code; b) a qualified high risk pool described in section 2744(c)(2) of the Public Health Services Act, or c) any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health insurance coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition 1) are unable to acquire medical care coverage for such condition through insurance or from an HMO or 2) are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.
8. A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).
9. A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance coverage to individuals who are enrolled in the plan.
10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504[e]).

Coverage under items 1-10 above will not be taken into account if there has been a Significant Break in Coverage.

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.

ELECTRONIC PROTECTED HEALTH INFORMATION: This term has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

ELIGIBLE DEPENDENTS:

Effective February 1, 2011, the following definition will apply:

The Eligible Employee's spouse, unless divorced, and all children from birth to twenty-six (26) years of age. 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 for whom the Eligible Employee is the child's legal guardian.

Such children do not need to live with the Eligible Employee or to be financially dependent upon the Eligible Employee for support. Such children do not need to be Full-Time Students, and they are also eligible if they are married and/or employed; however, prior to January 1, 2014, if they are eligible to receive benefits under an employer sponsored health plan (other than a group health plan sponsored by the employer of either parent), they will not be eligible for this coverage (on or after January 1, 2014, they will be eligible for this coverage). Dependents of such children will not be eligible for coverage.

A child who is physically or mentally incapable of self-support upon attaining the age of twenty-six (26) may be considered an Eligible 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.

The term "Eligible Dependent" shall not include any dependent who is covered as an Eligible Employee. Also, if both parents are employed by the Employer, children will be covered only as Eligible Dependents of one parent.

The Plan will provide written notice of the opportunity to enroll. Children whose coverage under the Plan ended, who were denied coverage or who were not eligible for coverage because the availability of dependent coverage of children under the Plan ended before attainment of age 26 may be eligible for this coverage, and children who previously reached the maximum age for coverage under the plan and elected COBRA continuation coverage will be eligible for continued coverage under this provision when this change becomes effective.

A special enrollment period for children who meet the criteria will take effect from December 1, 2010 through December 31, 2010, with coverage taking effect on February 1, 2011. To enroll children for this coverage, the parent should request the appropriate enrollment materials from the Employer.

In order for a child to be covered under these provisions, the Eligible Employee must also be enrolled for coverage.

If a child was covered under the previous definition of Eligible Dependents, he/she will remain covered up to the age limits shown in the new definition.

The following shall be added to the definition of Eligible Dependents for medical benefits only:

In compliance with Ohio House Bill 1 and any amendments thereto, eligibility will be extended for children to age 28 for medical coverage. To be eligible, a child must be unmarried and (1) the natural child, stepchild or legally adopted child of the Eligible Employee; (2) a resident of Ohio or a Full-Time Student; (3) not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and (4) not eligible for Medicaid or Medicare. Such children do not need to live with the Eligible Employee or to be financially dependent upon the Eligible Employee for support. Children who fit into the parameters outlined above (and who do not otherwise meet the definition of Eligible Dependent outlined in the plan document) may enroll for coverage on the effective date of this addendum or when the Plan is notified that the child has experienced a change in circumstances and has become newly eligible for coverage under state law. Such children will be able to enroll for coverage during the open enrollment period outlined in the Plan. However, the dependents of such children will not be eligible for coverage under this provision. A special enrollment period for children who meet the criteria will take effect from December 1, 2010 through December 31, 2010, with coverage taking effect on February 1, 2011. To enroll children for this coverage, the parent should request the appropriate enrollment materials from the Employer. Children who previously reached the maximum age for coverage under the plan and elected COBRA continuation coverage will be eligible for continued coverage under this provision when this change becomes effective. Children who come under this category will be charged a premium for coverage, and they 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. 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 enrollment department at the Plan Supervisor's office. If the check is returned for insufficient funds, the premium will be deemed to be unpaid. When the child reaches age 28 and loses coverage under this Plan, the child may elect COBRA or medical conversion coverage.

The following definition applies prior to February 1, 2011: The Eligible Employee's spouse, unless divorced, and all unmarried children from birth to nineteen (19) years of age (in other words, through age 18). 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 Eligible Employee is the head and actually being supported by the Eligible Employee within the meaning of the Internal Revenue Code (provided the Eligible Employee is related to the child by blood or marriage or is the child's legal guardian).

In addition to the above, children will be considered as Eligible Dependents from age nineteen (19) to twenty-five (25) (in other words, through age 24) if they are unmarried, Full-Time Students and are dependent upon the Eligible Employee or his spouse for financial support and maintenance. It is the Eligible Employee's responsibility to provide the Plan Supervisor with proof of Full-Time Student status (from the school) for each semester. The Eligible Employee must notify the Employer when the Eligible Dependent is no longer a Full-Time Student.

A child who is physically or mentally incapable of self-support upon attaining the age of nineteen (19) may be considered an Eligible 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.

The term "Eligible Dependent" shall not include any dependent who is covered as an Eligible Employee, nor any dependent child who is married. Also, if both parents are employed by the Employer, children will be covered only as Eligible Dependents of one parent.

ELIGIBLE EMPLOYEES: Employees who were employed prior to 2/1/02 and who are regularly scheduled to work at least 24 hours per week are eligible to be covered by the Plan. Employees who were employed on or after 2/1/02 and who are in active pay status at least 32 hours per week on a regularly scheduled basis are eligible to be covered by the Plan. Elected officials and County Commissioners are also included in this definition. Seasonal, intermittent and temporary employees are not eligible for benefits.

EMERGENCY CARE: Treatment for a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

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

EMERGENCY HOSPITAL ADMISSION: An Emergency Hospital Admission is defined as an admission for Inpatient Hospital confinement for a condition which, unless immediately treated only on an Inpatient basis, would jeopardize the patient's life or cause serious impairment to the patient's bodily functions.

EMPLOYER: The Employer is Jefferson County.

ENROLLMENT DATE: The first day of coverage under the Plan or, if there is a Waiting Period, the first day of the Waiting Period.

ESSENTIAL HEALTH BENEFITS: Such benefits include ambulatory patient services, emergency services, hospitalization, maternity and newborn care; mental health and substance disorders; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services, chronic-disease management and pediatric services, including oral and vision care.

EXPERIMENTAL OR INVESTIGATIONAL: One or more of the following is true of a treatment, procedure, device, drug, or medicine:

1. It cannot be lawfully marketed without U.S. Food and Drug Administration approval; and approval for marketing for the condition treated has not been given at the time the device, drug or medicine is furnished;

2. Reliable evidence shows that to determine its maximum tolerated dose, toxicity, safety, efficacy (or efficacy as compared with the standard means of treatment or diagnosis):

- a. It is undergoing phase I, II, or III clinical trials or is under study; or
- b. further clinical trials or studies are needed, according to the experts' consensus of opinion.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; or the written protocol or written informed consent used by the treating facility (or by another facility studying substantially the same treatment, procedure, device, drug or medicine).

Experimental or Investigational shall also mean:

1. Any treatments, services, supplies or related expenses that are educational or provided primarily for research; or
2. Treatments, procedures, devices, drugs or medicines or other expenses relating to the transplant of non-human organs.

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 Eligible 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. A child will continue to be a Full-Time Student during periods of regular vacation established by the institution. If the person does not continue as a Full-Time Student immediately following the period of vacation, the Full-Time Student designation will end on the last day of the school term that was attended on a full-time basis.

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.

HOME HEALTH CARE AGENCY: The term "Home Health Care Agency" means only a public or private agency or organization, or a sub-division thereof, that (a) is primarily engaged in providing skilled nursing and other therapeutic services, (b) has policies established by associated professional personnel, including one or more Physicians and one or more Registered Professional Nurses (R.N.), to govern the services provided under the supervision of such a Physician or nurse, (c) maintains clinical records on all patients, and (d) in cases where the applicable state or local law provides for the licensing of agencies or organizations of this nature, the latter are licensed or approved by the state or local law as meeting the standards established for such licensing. In no event will the term "Home Health Care Agency" include one which is engaged primarily in the care and treatment of mental disease.

HOSPICE: An agency that provides counseling and incidental medical services and may provide room and board to a terminally ill person and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval;
2. It provides 24-hour-a-day, 7-day-a-week service;
3. It is under the direct supervision of a duly qualified Physician;
4. It is an agency that has as its primary purpose the provision of Hospice services;
5. It has a full-time administrator;
6. It maintains written records of services provided to the patient;
7. Its employees are bonded, and it provides malpractice and malplacement insurance; and
8. It is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law.

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 Healthcare Organizations.
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 Professional Nurses (R.N.); 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.

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 any other covered facility for treatment, and charges are made for room and board to the Covered Person as a result of such treatment. A Covered Person 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.

LATE ENROLLEE: An Eligible Employee or Eligible Dependent who is not enrolled in the Plan on the earliest date possible in accordance with the requirements of the Eligibility and Effective Date of Coverage provisions of this Plan, unless such person is a Special Enrollee.

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 and any other such organizations.

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.

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.

OPTOMETRIST: A person duly licensed to practice optometry by the governmental authority having jurisdiction over the licensing and practice of optometry in the locality where the service is rendered.

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 at a covered facility 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, audiologist 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. For purposes of this Plan, a licensed professional counselor will be considered as a Physician, and a social worker working under the supervision of a psychologist or psychiatrist will be considered as a Physician.

PLAN: The Plan is The Jefferson County Employee Health Plan.

PLAN ADMINISTRATOR: The Plan Administrator is the Employer, which 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 also the Plan Sponsor and named fiduciary.

PLAN SPONSOR: The Plan Sponsor is the Employer.

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.

PLAN YEAR: The Plan Year runs from February 1st to January 31st of each year.

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.

REASONABLE AND CUSTOMARY CHARGE (R & C): The Reasonable and Customary 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 Reasonable and Customary 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 the Reasonable and Customary Charge takes into consideration any unusual circumstances or complications which require additional time, skill or experience in connection with the particular service or procedure. This Plan will allow the 50th percentile of the Reasonable and Customary tables. If services are rendered by a PPO Provider, the allowable amount established by the PPO will be considered the Reasonable and Customary Charge.

SECURITY INCIDENTS: This term has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

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.

SIGNIFICANT BREAK IN COVERAGE: A period of sixty-three (63) consecutive days during all of which the individual does not have any Creditable Coverage, except that neither a Waiting Period nor an affiliation period is taken into account in determining a Significant Break in Coverage.

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 Eligible 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 an Eligible Dependent, the inability to perform the normal duties of a person of the same sex and of comparable age.

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.

WAITING PERIOD: A continuous period of sixty (60) days commencing on the first day a person is an Eligible Employee.

MEDICARE PROVISION

For those Eligible Employees (who have Plan coverage by virtue of their current employment status as defined in Medicare) or spouses of Eligible Employees (who have Plan coverage by virtue of the Eligible Employee's 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 as secondary payor. 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 (who have Plan coverage by virtue of their current employment status as defined in Medicare), or Eligible Dependents (who have Plan coverage by virtue of a family member's current employment status as defined in Medicare), 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 primary benefits, unless the Eligible Employee or Eligible Dependent refuses coverage under this Plan. If such Eligible Employee or Eligible Dependent refuses coverage under this Plan, Medicare will be the sole source of benefits. Eligible Employees or Eligible Dependents 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 Eligible Dependent refuses coverage under this Plan. Any charges which are not paid under this Plan should be submitted to Medicare as secondary payor. 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 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.

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) or because of disability (other than End Stage Renal Disease), 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. Medical, Dental and Vision Benefits 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 (1) 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 do 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, 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. The Covered Person's benefits under automobile "no fault" and "fault" insurance, including uninsured and underinsured motorist coverage, and medical payment coverage is determined before the benefits 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, 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; and
6. Any coverage for students which is sponsored by, or provided through, a school or other educational institution.

SUBROGATION

By enrolling for coverage under the Plan, Covered Persons understand and agree that if Illness, Injury or other condition to a Covered Person is caused by an act or omission of a third party or the Covered Person, the Plan may, if the requirements of this section are satisfied, advance benefits for medical expenses incurred as a consequence of the act or omission. In addition, Covered Persons agree that if any payments are made to or on behalf of a Covered Person and such payments have arisen 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 benefits advanced by this 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 claim. For example, should the Plan advance benefits totaling \$90,000 on behalf of a Covered Person involved in a subrogation matter, and that Covered Person receive a full and final settlement in the amount of \$60,000, the Plan would be entitled to recover the \$60,000 amount which, assuming no other source of recovery, would serve to fully satisfy the Plan's subrogation interest in that matter, regardless of any other expenses, such as attorneys' fees or privately paid medical costs which are not covered by Plan provisions. The Plan shall maintain a lien on any such recovery and be entitled to reimbursement in full in accordance with this section, irrespective of whether the settlement monies received by the Covered Person leave a Covered Person fully compensated or "made whole" for all or any of said claims. The Plan shall be entitled to such reimbursement from first dollar recovery amounts received by the Covered Person and as such shall specifically have priority over any other interests including, without limitation, any unpaid medical expenses not submitted through the Plan for any party, attorneys' fees (regardless of whether they are considered contingent or hourly) and legal costs and shall supersede the Covered Person's right to be made whole. 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 benefits advanced by the Plan. The Covered Person agrees to cooperate with and assist the Plan in obtaining or providing any information or document production necessary to support the subrogation rights of the Plan. Any Covered Person who 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, such as withholding information from the Plan regarding third party insurance company's contact information, policy limits or concealing development of any legal proceedings or settlements between legal representatives of Covered Persons and any third parties. 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 advance benefits to or on behalf of the Covered Person. The Plan Supervisor shall withhold payments of claims made under this Plan, to the extent that the Plan Supervisor has reason to believe that said claims arise as a result of any act of a third party, until the Covered Person or the Covered Person's legal representative executes the forms required by the Plan without alteration or modification. The subrogation rights of the Plan, as set forth in this section, shall also apply to payments made by the Covered Person's own insurance or his own or any auto insurance, including, but not limited to, medical payments coverage, any excess, umbrella, uninsured/underinsured motorists coverage, personal protection policies issued under 'no-fault' coverage provisions, and/or any other applicable insurance coverage (with the exception of payment for property damage). For purposes of this section and any Agreement executed pursuant hereto, the term Covered Person shall include the dependents, heirs, guardians, executors or other representatives of the Covered Person. For purposes of this section and any Agreement executed pursuant hereto, the spouses, children and other dependents as Covered Persons under the Plan are third party beneficiaries under the Plan and therefore subject to the same duties and obligations as employees who are Covered Persons under the Plan. The Plan shall have no obligation to share the cost of, or pay any part of, the Covered Person's attorney fees and costs incurred in obtaining any recovery against the third party. The Plan retains the right, at its sole discretion, to commence litigation against third parties, file claims or take any other action on behalf of the Covered Person, respective to the Plan's advanced benefits, should the Covered Person not commence litigation, file claims or take appropriate action within a reasonable period of time. Covered Persons must notify the Plan of the Covered Person's claim at the time the Covered Person files a lawsuit to recover damages or 90 days prior to the expiration of the statute of limitations, whichever is sooner. Should the Covered Person fail to comply with the requirements of this section, the Covered Person shall pay the Plan's reasonable collection costs and attorney fees incurred in collecting amounts due under the Plan.

MEDICAL BENEFIT CONVERSION

An individual health policy is available for an Eligible Employee and/or his Eligible Dependents, under age 65, whose coverage under this Plan ceases due to termination of employment, change in marital status or loss of eligibility. 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 premium must be paid within 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

The Plan may, without the consent of or notice to any person, release to or obtain from any insurance company or any other party, any information which the Plan deems relevant for the purpose of applying and implementing the terms of the Plan. Any person claiming benefits under the Plan shall furnish to the Plan such information as may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payments that should have been made under this Plan were made by another plan, this 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 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 paid, to the extent of such excess from among one (1) 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.

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. Any Plan amendment shall be by a written instrument signed by a representative or representatives of the Employer who have been authorized by resolution or other appropriate authority to amend the Plan and shall become effective as of the date specified in the instrument. A copy of such instrument shall be furnished to the Plan Administrator and any outside provider of Plan administration services.

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 (Filing 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 (12) months 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 bill should be sent to the address shown on the ID card.

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 Plan and the Plan Administrator.

APPEAL PROCEDURES

If a claim is denied in whole or in part, the Plan Supervisor will provide written notification to the Eligible Employee 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 such information.

If a claim is denied in whole or in part, the Eligible Employee may appeal the decision. The Eligible Employee or his authorized representative may examine pertinent documents (except for information in the file which the Physician does not wish made known to the claimant), and the Eligible Employee may send a written letter of appeal outlining his 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 the Eligible Employee (or his authorized representative) which references the pertinent Plan provisions supporting the decision. Unless the "Independent Review Provisions" apply, this decision will be final.

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 or to be a consideration for, or an inducement or condition of, the employment of an employee. Nothing in the Plan shall be deemed to give an Employee 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 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.

BOOKLETS

The Plan Sponsor has issued herewith to each covered Eligible Employee 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 Eligible Employee and his Eligible Dependents. In the event of any discrepancies between the booklet and the plan document, the plan document will govern.

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.

MEDICAL CHILD SUPPORT ORDERS

The Plan will follow the applicable state requirements, if any, for orders issued by: (1) a court of competent jurisdiction, or (2) through an administrative process established under state law that has the force and effect of law under applicable state law, that establishes a parent's obligation to provide health coverage to children who are Eligible Dependents and who are the subject(s) of such order, provided such order does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan.

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
4. the request is accompanied by 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.

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/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
 Jefferson County Government
 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) 575-5370 or (800) 919-3311.

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

EXPEDITED REVIEW OF MEDICAL NECESSITY
 Jefferson County Government
 c/o Medillume III, Inc.
 Via Fax Transmission
 and fax to (216) 566-0171

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
 Jefferson County Government
 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
Jefferson County Government
c/o Medillume III, Inc.
Via Fax Transmission
and fax to (216) 566-0171

PROHIBITION OF RESCISSION OF COVERAGE

This Plan shall not rescind coverage for individuals who are covered under the plan, except in cases where the individual has engaged in fraud or made an intentional misrepresentation of material fact, as prohibited by the terms of the Plan and with advance notice. The term Rescission shall mean a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage is *not* a rescission if the cancellation or discontinuance of coverage has only a prospective effect; or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. The Plan must provide at least 30 days' advance written notice to each participant who would be affected before coverage may be rescinded.

HIPAA PRIVACY PROVISIONS

This provision is intended to bring the Plan into compliance with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and § 164.504(f) is referred to as "the "504" provisions") by establishing the extent to which the Plan Sponsor will receive, use and/or disclose Protected Health Information.

1. The Plan's Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan Sponsor designates one of its Deputy Auditors to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts and accepting certification from the Plan Sponsor).

2. Definitions

All terms defined in the HIPAA Privacy Rule, shall have the meaning set forth therein.

3. The Plan's disclosure of Protected Health Information to the Plan Sponsor - Required Certification of Compliance by Plan Sponsor

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose Protected Health Information to the Plan Sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor by a health insurance issuer or HMO with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

- a. the plan documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the "504" provisions;
- b. the plan documents have been amended to incorporate the Plan provisions set forth in this addendum; and
- c. the Plan Sponsor agrees to comply with the Plan provisions as modified by this addendum.

4. Permitted disclosure of individuals' Protected Health Information to the Plan Sponsor

- a. the Plan (and any business associate acting on behalf of the Plan), or any health insurance issuer or HMO servicing the Plan will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this addendum.
- b. all disclosures of the Protected Health Information of the Plan's individuals by the Plan's business associate, health insurance issuer, or HMO to the Plan Sponsor will comply with the restrictions and requirements set forth in this addendum and in the "504" provisions.
- c. the Plan (and any business associate acting on behalf of the Plan), may not, and may not permit a health insurance issuer or HMO, to disclose individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- d. the Plan Sponsor will not use or further disclose individuals' Protected Health Information other than as described in the plan documents and permitted by the "504" provisions.
- e. the Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the Plan (or from the Plan's health insurance issuer or HMO), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.
- f. the Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- g. the Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the plan documents (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

5. Disclosure of individuals' Protected Health Information - Disclosure by the Plan Sponsor

- a. the Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. § 164.524.
- b. the Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. §164.526.
- c. the Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. §164.528.

- d. the Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.
 - e. the Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the Plan (or a health insurance issuer or HMO with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
 - f. the Plan Sponsor will ensure that the required adequate separation, described in item 7 below, is established and maintained.
- 6. Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor**
- a. the Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan Sponsor without the need to amend the plan documents as provided for in the "504" provisions, if the Plan Sponsor requests the summary health information for the purpose of:
 - (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
 - (2) modifying, amending, or terminating the Plan.
 - b. the Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the plan documents as provided for in the "504" provisions.
- 7. Required separation between the Plan and the Plan Sponsor**
- a. in accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may be given access to individuals' Protected Health Information received from the Plan or from a health insurance issuer or HMO servicing the Plan:
 - The Deputy Auditors designated by the Employer;
 - The Commissioners designated by the Employer;
 - Director of Data Processing;
 - Computer Programmers designated by the Employer; and
 - Assistant Clerk, Commissioners' Office
 - b. this list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who receive individuals' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan sponsor provides for the Plan. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this addendum.
 - c. The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

HIPAA SECURITY STANDARDS

This provision is intended to bring the Plan into compliance with the requirements of 45 C.F.R § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. Parts 160, 162 and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing the Plan Sponsor's obligations with respect to the security of Electronic Protected Health Information.

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

1. The Plan Sponsor shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan.
2. The Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F. R § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures.
3. The Plan Sponsor shall ensure that any agent, including a subcontractor to whom it provides Electronic Protected Health Information, agrees to implement reasonable and appropriate security measures to protect such Information; and
4. The Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - a. Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification or destruction of the Plan's Electronic Protected Health Information; and
 - b. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

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.
- * For vision claims, complete the Employee's Statement, have the provider complete the Statement of Physician or Optometrist, and return the 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 180 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 Jefferson County Employee Health Plan
2. **NAME & ADDRESS OF PLAN SPONSOR:**

Jefferson County Government	OME-RESA
301 Market Street	JEFFERSON COUNTY BD. OF EDUCATION
Steubenville, Ohio 43952	2023 SUNSET BOULEVARD
	STEUBENVILLE, OHIO 43952
3. **EFFECTIVE DATE OF PLAN:** This plan document reflects amended and restated benefits which are effective February 1, 2004.
4. **EMPLOYER IDENTIFICATION NUMBER:** 34-6001501
5. **PLAN NUMBER:** 501
6. **ACCOUNT NUMBER:** 506-793
7. **TYPE OF PLAN:** This is a welfare plan providing medical, dental and vision benefits.
8. **TYPE OF ADMINISTRATION:** This is a self-insured plan. Certain administrative services are provided by a contract administrator retained by the Employer. Self-Funded Plans, Inc., which is not an insurance company, is the contract administrator.
9. **NAME, BUSINESS ADDRESS & TELEPHONE NUMBER OF THE PLAN ADMINISTRATOR:**
Jefferson County Government
301 Market Street
Steubenville, Ohio 43952
(740) 283-8500
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:**
Benefits provided under the Plan shall be unfunded and shall be paid solely from the general assets of the Employer. No employees shall have any right, title, or interest whatsoever in or to any investment reserves, accounts, or funds that the Employer may purchase, establish, or accumulate to aid in providing benefits under this Plan. Nothing contained in this Plan, and no action taken under its provisions, shall create a trust or fiduciary relationship of any kind between the Employer and a Covered Person. A Covered Person shall not acquire an interest greater than that of an unsecured creditor. The Employer requires employees to contribute to the cost of coverage through enrollment in an IRS Section 125 cafeteria plan using salary reduction agreements.
12. This Plan believes that it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act (for example, the elimination of lifetime limits on benefits). Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator outlined in the plan document and summary plan description. Participants may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.