NSSEO Orientation Handbook

Certified/Licensed Employees

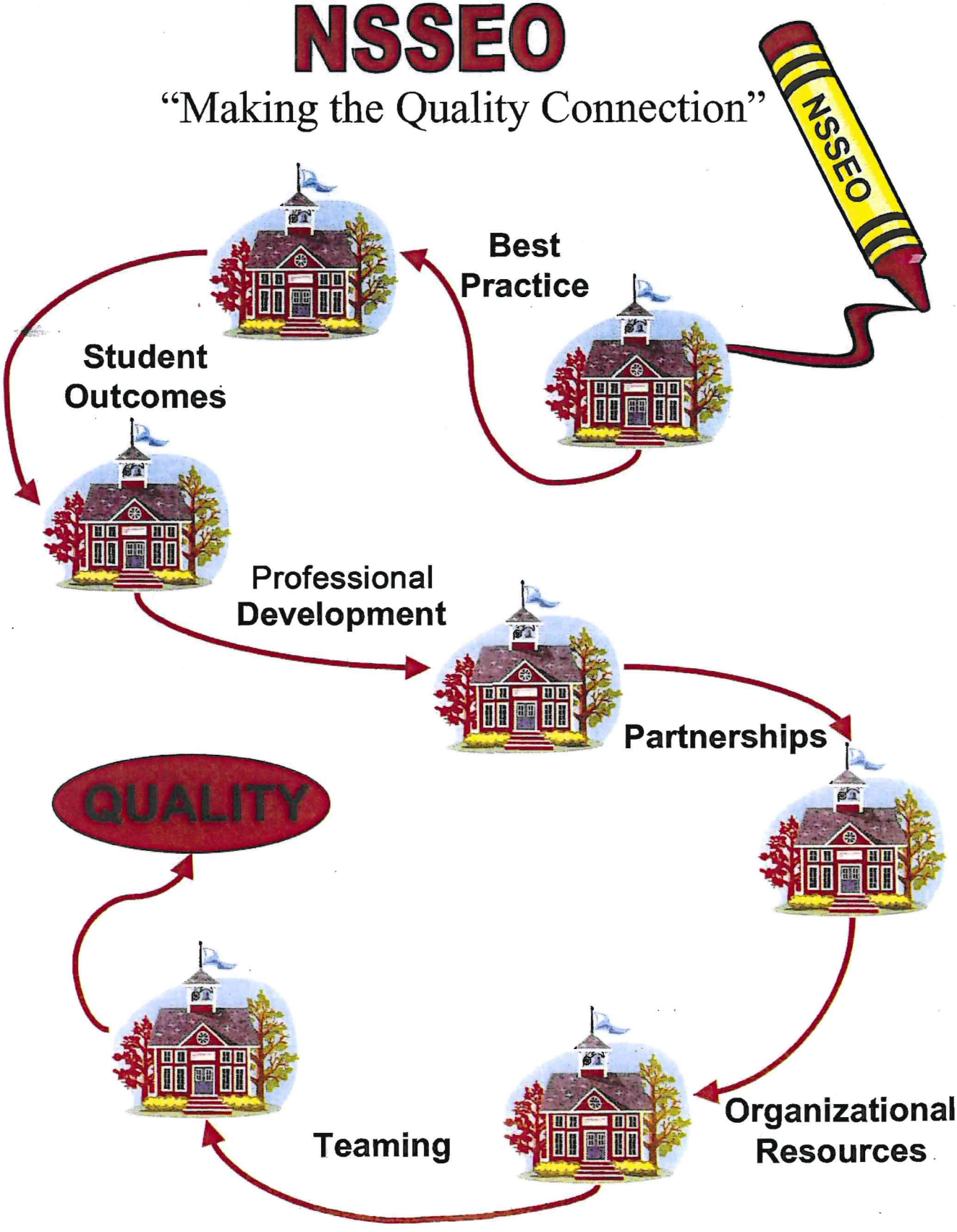
Contents

Booklet Enclosures/Brochures

- ✓ Understanding NSSEO Polices and Guidelines
- ✓ School Pesticide Notification
- ✓ Benefit Package
- ✓ Direct Deposit
- ✓ AAEC/Metro Credit Unions
- ✓ Voice & E-mail Guides
- ✓ Aesop

NSSEO

"Making the Quality Connection"



Building a promising future for students

NSSEO

Northwest Suburban Special Education Organization

Program Locations

NSSEO Program and Service Locations

- **NSSEO Administration Building**
  799 West Kensington Road
  Mt. Prospect, Illinois 60056-1111
  847.463.8100 Fax: 847.463.8114
  Dr. Judith Hackett, Superintendent Executive Assistant, Ann Klimara

- **NSSEO Administration Building Services**
  Accounts Payable – Lisa Simon
  Accounts Receivable - Holly Sabaini
  Business Services – Julie Jilek
  Cathy Williams, Diane DiGiovanni, Marcia Guiffre, Lisa Simon, Martha Polen
  Assistive Technology Program (Augmentative Communication) - Rachele Dadouche-Nowak
  Insurance – Julie Jilek, Kim Cowles
  Payroll - Cyd Walloch
  Human Resources-Cathy Kostecki, Linda Maine, Betty Barker, Kim Cowles
  Instructional Services-Cathy Kostecki
  Staff Development/Community Relations - Barbara Hammes, Alison Harrald
  Transportation – Julie Jilek, Marcia Guiffre
  Wellness Program, EAP – Julie Jilek
  Child Count – Mike Harwood

- **Diagnostic and Educational Services Center (DESC)**
- **Transitional Program of Instruction for Limited English Proficient Students**
  Gillet Educational Center
  201 South Evanston
  Arlington Heights, Illinois 60004-6899
  847.463.8240 Fax: 847.463.8275
  Shelle Hamer, Diagnostic Educational Services Coordinator
  Program Administrative Assistant, Kathy Glickman
  Program Administrative Assistant, Debbie Skoskiewicz

Program and Service Locations (continued)

- **Technical Assistance Supervision**
  799 West Kensington Road
  Mount Prospect, Illinois 60004-1111
  847.463.8100 Fax: 847.463.8196
  Coordinators:
  Rachele Dadouche-Nowak, Speech/Lang. /Asst. Tech. Coordinator
  Kim Brown, Autism Coordinator
  Ken Kozin, Dist. 214 Tech Assistance Coordinator
  Program Administrative Assistant, Linda Kozeluh

- **Kirk School**
  520 South Plum Grove Road
  Palatine, Illinois 60067-6933
  847.463.8500 Fax: 847.463.2623
  Kim Dungan, Principal
  Catherine Ivack, Assistant Principal
  Program Administrative Assistant, Julie Ruegger
  Program Administrative Assistant, Gina Podwika
  Program Administrative Assistant, Mary Hoffman

- **Miner School**
  1101 East Miner Street
  Arlington Heights, Illinois 60004-6337
  847.463.8400 Fax: 847.463.8415
  Maureen Daly, Principal/Coordinator of PBIS
  Lisa Murphy, Assistant Principal
  Program Administrative Assistant, Linda Boos
  Program Administrative Assistant, Lynn Lampert

- **Timber Ridge @ Gillet**
  201 S. Evanston
  Arlington Heights, Illinois 60004-6899
  847.463.8300 Fax: 847.463.8304
  Hassan von Schlegell, Principal
  Program Administrative Assistant, Cynthia Kindler

Program and Service Locations (continued)

- **Technology Education Center**
  NSSEO Administration Building
  799 W. Kensington Road
  Mount Prospect, Illinois 60056-1111
  847.463.8390 Fax: 847.463.8396
  Mary Ann McGinn, Technology Coordinator
  Program Administrative Assistant, Jean Nielsen

- **Cross-Categorical, (District 21)**
  Riley Elementary School
  1209 Burr Oak Drive
  Arlington Hts., IL 60004
  847.670.3400 Fax: 847.670.3418
  Maureen Daly, Program Coordinator
  Program Administrative Assistant, Lynn Lampert

- **Vocational Transition Program (VAC)**
  500 South Plum Grove Road
  Palatine, Illinois 60067-6933
  847.485.2290 Fax: 847.485.2295
  Greg Hill, Transition Specialist
  Nancy D'Andrea, Transition Specialist
  Program Administrative Assistant, Judy Johnson

- **NSSEO Maintenance**
  Kirk School
  520 South Plum Grove Road
  Palatine, Illinois 60067-6933
  847.485.2603 Fax: 847.485.2297
  Bob Parotto, Supervisor

- **Sunrise Lake Outdoor Education Center**
  7N 749 Route 59
  Bartlett, Illinois 60103-1630
  630.830.0146 Fax: 630.830.0227
  Bryan Bolger, Outdoor Education Specialist
  Program Administrative Assistant, Carol Alexander

NSSEO Member Districts

- Community Consolidated School District 21
  999 West Dundee Road
  Wheeling, Illinois 60090
  Dr. Gary Mical, Superintendent
  Kathy Edmonds, NSSEO Board President
  Dr. Candace Thompson, NSSEO Administrative Representative
  847.537.8270

- Prospect Heights Public School District 23
  700 North Schoenbeck Road
  Prospect Heights, Illinois 60070
  Dr. Greg Guarrine, Superintendent
  Martha Olsen, NSSEO Board Secretary
  Dr. Deb Wilson, NSSEO Administrative Representative
  847.870.3850

- Arlington Heights Public School District 25
  1200 South Dunton Avenue
  Arlington Heights, Illinois 60005
  Dr. Sarah Jerome, Superintendent
  Charles Williams, NSSEO Board Member
  Dennis Joyce, NSSEO Administrative Representative
  847.758.4900

- River Trails School District 26
  1900 East Kensington Road
  Mount Prospect, Illinois 60056
  Dr. Dane Delli, Superintendent
  Frank Fiarito, NSSEO Board Member
  Miriam Cutler, NSSEO Administrative Representative
  847.297.4120

- Mount Prospect School District 57
  701 West Gregory Street
  Mount Prospect, Illinois 60056
  Dr. Elaine Aumiller, Superintendent
  Sann Knipple, NSSEO Board Member
  Donna Toops, NSSEO Administrative Representative
  847.394.7300

Member Districts (continued)

- Community Consolidated School District 59
  2123 South Arlington Heights Road
  Arlington Heights, Illinois 60005
  Dr. Daniel Schweers, Superintendent
  Sharon Roberts, NSSEO Board Vice President
  Val Gudgeon, NSSEO Administrative Representative
  847.593.4300

- Township High School District 211
  1750 South Roselle Road
  Palatine, Illinois 60067
  Dr. Nancy N. Robb, Superintendent
  Anna Klimkowicz, NSSEO Board Member
  Julie Nowak, NSSEO Administrative Representative
  847.755.6600

- Township High School District 214
  2121 South Goebbert Road
  Arlington Heights, Illinois 60005
  Dr. David Schuler, Superintendent
  William Dussling, NSSEO Board Member
  Johnnie Thomas, NSSEO Administrative Representative
  847.718.7600

Building a promising future for students

NSSEO

Northwest Suburban Special Education Organization

New Employee Information

Building a promising future for students

NSSEO

Northwest Suburban Special Education Organization

2011-2012
NSSEO SCHOOL CALENDAR

2011			**Staff**	**Students**
August 17	Wednesday	New Staff Orientation		
August 18	Thursday	New Staff Orientation		
August 19	Friday	New Staff Orientation		
August 22	Monday	Institute Day	Yes	No
August 23	Tuesday	Institute Day	Yes	No
August 24	Wednesday	First Day of School	Yes	½ Day
September 5	Monday	Labor Day Holiday	No	No
September 16	Friday	Teacher Inservice	Yes	½ Day
September 29	Thursday	Non-Attendance Day	No	No
October 10	Monday	Columbus Day Holiday	No	No
October 28	Friday	Teacher Inservice	Yes	½ Day
October 28	Friday	**End of First Quarter**		
November 9	Wednesday	Evening Parent Conference (4-7pm)	Yes	
November 10	Thursday	Evening Parent Conference (5-8pm)	Yes	
November 11	Friday	Veterans Day Holiday	No	No
November 23	Wednesday	Conference Day-Non Attendance	**	No
November 24	Thursday	Thanksgiving Holiday	No	No
November 25	Friday	Non Attendance Day	No	No
December 19	Monday	Winter Recess Begins	No	No
2012				
January 2	Monday	Non Attendance Day	No	No
January 3	Tuesday	First Day of School after Winter Recess	Yes	Yes
January 16	Monday	Martin Luther King's Birthday Holiday	No	No
January 20	Friday	Institute Day	Yes	No
January 20	Friday	**End of Second Quarter**		
January 23	Monday	NSSEO Institute Day	Yes	No
February 8	Wednesday	Teacher Inservice	Yes	½ Day
February 20	Monday	President's Day Holiday	No	No
March 26	Monday	Spring Recess Begins	No	No
April 2	Monday	First Day of School after Spring Break	Yes	Yes
April 6	Friday	Non Attendance Day	No	No
April 6	Friday	**End of Third Quarter**		
April 9	Monday	Teacher Inservice	Yes	No
May 28	Monday	Memorial Day Holiday	No	No
*June 8	Friday	Last Day of School – Early Dismissal	Yes	Yes
*June11	Monday	Last Day of School – Early Dismissal		

Total Days: Students – 178

* If NSSEO does not close school more than 2 days due to inclement weather, June 8th will be the last day of school.

** Non Attendance day for staff who have worked the two evening parent teacher conferences on Nov 9th and 10th.

11-12-SchCal.doc
Approved by NSSEO Governing Board: 3/02/2011

ASSISTIVE TECHNOLOGY

The *Assistive Technology Program* is any item, piece of equipment or product system, whether acquired commercially off the shelf, modified, or customized or teacher/therapist made that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. The assistive technology staff provides evaluation and support to students, school personnel and parents in the areas of assistive technology.

CROSS-CATEGORICAL MINER SCHOOL

Miner School provides a cross categorical instructional program for children ages 5 through 21, who exhibit learning disabilities, middle mental and physical disabilities.

RILEY SCHOOL

The cross categorical program at *Riley School* serves primary and intermediate students who exhibit developmental delay which are considered mild to moderate. These children may have physical disabilities, autism, Down Syndrome or a variety of other handicapping conditions. Some children may benefit from mainstreaming in general education classes.

KIRK SCHOOL

Kirk School serves students ages 5 through 21 who demonstrate moderate to profound mental impairment. In addition, students also have physical and/or sensory deficits, and other multiple needs.

TIMBER RIDGE SCHOOL

Timber Ridge School provides an alternative education for students ages 5 through 14 who have significant emotional or behavioral needs which interfere with their ability to participate in special education program in a regular school building.

DIAGNOSTIC AND EDUCATIONAL SERVICES CENTER

The *Diagnostic and Educational Services Center (DESC)* provides a variety of assessments, consultation, and direct services to our member districts. The most commonly requested services include in depth Case Study or Section 504 evaluation. Districts can also request on-site consultation, assistance in securing outside medical, neurological, psychiatric evaluations, and the coordination of occupational therapy, social work, and adapted physical education.

PROFESSIONAL DEVELOPMENT

The *Professional Development Program* supports member districts and NSSEO programs in providing a coordinated staff development program in special education and in general education regarding special education students.

LOW INCIDENCE COOPERATIVE AGREEMENT

The *Low Incidence Cooperative Agreement (LICA)* serves children who are deaf or hard of hearing from birth to age 21 who reside within 45 school districts in the north and northwest suburbs of Chicago. The scope of responsibility includes diagnosis, instruction, supervisory case management and student and parent support services.

SUNRISE LAKE OUTDOOR EDUCATION

Sunrise Lake Outdoor Education Center provides three programs:

1. The Day Program for all NSSEO and member districts. Each student partakes in a number of different lessons that develops gross and fine motor control, nature awareness, vocational skills, artistic expression, and individual and group problem solving abilities.
2. The Overnight Program where students are able to participated in many of the same lessons as the Day Program but to a greater depth and intensity.
3. Adventure Education Program which are trips throughout the Midwest that last for 3 to 7 days.

TECHNICAL ASSISTANCE SUPERVISION

Technical Assistance Supervision is provided by NSSEO coordinators to member districts and district programs in all categorical areas of special education, i.e., speech and language, learning disabilities, behavior disorder, mental impairment, early childhood, physically handicapped and visually impaired.

TRANSPORTATION

NSSEO coordinates the transportation of approximately 450 students directly to school sites for member districts 21, 25, 57, 59, and 214 and to other sites such as Sunrise Lake outdoor Education Center, work stations, mainstreaming sites, field trips, and community based training experiences.

TRANSITION SPECIALIST PROGRAM

The *Transition Specialist Program* is a cooperative agreement between high school districts 211, 214, NSSEO and the Illinois Department of Rehabilitation Services and provides vocational services for students through the Secondary Transitional Experience Program (STEP). Assistance in placement of post school programs and follow up for graduating students still in need of specialized vocational services are provided.

VISUALLY IMPAIRED SUPPORT SERVICES

The *Visually Impaired Support Services Program* provides specialized instruction related to students who have a visual impairment by providing instruction in orientation and mobility skills, rehabilitation and direct vision instruction in the classroom, school, community and home.

PERSONNEL FILES

All new employees are responsible for submitting all documents required to complete their personnel file. A list of required documents is sent with the offer of employment. Documents should be submitted to the Program Administrative Assistant. Many of these documents are required by state or federal law; **paychecks must be picked up from the Director of Human Resources and Instructional Services** if files are not complete within 30 days of employment.

PAYROLL

Paychecks are usually issued on the 15th and the 30th of each month. In December the second paycheck will be issued before winter break. If the pay date falls on a Monday the checks normally sent by US mail will be mailed that morning. Payroll schedule can be found on the NSSEO web site (www.nsseo.org).

Salaries for full-time certified/registered/licensed personnel (speech therapists, nurses, teachers, diagnosticians, ADL and O&M specialists, psychologist, social workers, physical and occupational therapists, mainstream specialists, pre-vocational and vocational teachers/coordinator) are spread over 12 months or 24 pay periods.
Aide and assistant salaries, including COTA and PTA, are spread over 12 months or 24 pay periods.

All 11 and 12 month, full-time employees (Program Administrative Assistants and custodians) salaries are spread over 12 months or 24 pay periods. This category of employees also earns vacation benefits.

Full-time 10 month Program Administrative Assistants' salaries are spread over 12 months or 24 pay periods.

Part-time employees are paid annual salary based on the full time rate at the part time percent. This salary is spread over 12 months or 24 pay periods. Part-time employees who work under 31 hours per week do not receive benefits.

NSSEO provides Direct Deposit services. Complete the direct deposit form and return to the payroll department for processing with your bank. Direct deposit will not begin until all required paperwork is on file with Human Resources.

BENEFITS

All NSSEO employees working 31 hours or more per week are eligible for benefits.

INSURANCE

Group hospital, major medical, dental and life insurance premiums are provided by NSSEO for full-time employees. Employee contributions towards premiums are determine by the collective bargained agreements or approved benefits from the Governing Board. Medical and dental coverage for eligible dependents can be obtained at an additional charge to the employee. Optional life insurance for dependents is available at the employee's expense. The optional life insurance is available only on the payroll deduction plan.

Insurance is effective 30 days from the first working day and remains in effect until 30 days from the last day of work in the case of termination during the school year. Insurance coverage remains in effect through August for staff members who work until the end of the school year. A conversion privilege is available to employees within 31 days of termination. All terminating employees receive notification of procedures for extending converting coverage per state law. Contact Kim Cowles at the NSSEO central office for further information.

Insurance enrollment cards should be completed and returned to Program Administrative Assistant on the first day of work.

SICK LEAVE

Full-time employees may use sick leave days for illness in the immediate family. Immediate family shall be interpreted as brothers, sister, children, parents, spouse, grandparents, grandchildren, parents-in-law, brothers-in-law, sisters-in-law, and legal guardians. In unusual circumstances, requests may be made to the Superintendent/designee, who may at his/her discretion, grant the use of sick leave days for the illness of person(s) other than those included in the definition of immediate family. Absence due to pregnancy-related disability shall be treated as sick leave if the employee does not take a parental leave.

A physician's verification is required whenever sick leave is taken on three consecutive days.

Certified/Licensed

All tenured employees are authorized up to fifteen (15) days of paid sick leave per year. Non-tenured employees are authorized ten (10) days of paid sick leave with two (2) days immediately being contributed to the Sick Leave Bank. Sick leave may accumulate to 340 days as determined in bargained agreement or as allowed by TRS or IMRF.

PERSONAL BUSINESS LEAVE

Each full-time employee may use up to two (2) days annually without loss of pay and not deducted from allowable sick leave, to conduct personal business.

Personal business involves situations with importance or urgency which cannot be reasonably controlled and where these important matters cannot be attended to at times other than during work hours. Personal business days are not to be used for recreational purposes or to extend vacation periods.

Except for cases of emergency, personal business leave should not be requested during the first five days or last five days of school, or on the day before or after vacation or holiday. As with all leave days for personal business, the approval of the program supervisor and the Superintendent is required prior to the leave being taken.

BEREAVEMENT LEAVE

Each employee shall be given up to three (3) days per occurrence for death in the immediate family without loss of pay. The immediate family shall include: brothers, sisters, children, parents, spouse, grandparents, grandchildren, parents-in-law, brothers-in-law, sisters-in-law, and legal guardians. In unusual circumstances, requests may be made to the Superintendent/designee, who may at his/her discretion, grant the use of bereavement days for the death of person(s) other than those included in the definition of immediate family.

ASSOCIATION-Northwest Suburban Special Education Association (NSSEA/NSSEA-ESP)

NSSEA is a professional association representing all full-time certified/license staff except administrators. All full-time aides/assistants including COTA and PTA are represented by the NSSEA-ESP. NSSEA is a local affiliate of the Illinois Education Association (IEA) and the National Educations Association (NEA). As members of IEA and NEA, the members of NSSEA/NSSEA-ESP are extended the services and programs available through the state and national organizations. For a listing of positions represented by the NSSEA, refer to the NSSEA contracts. Program Administrative Assistants and NSSEO Human Resources can refer employees to NSSEA building representatives.

RETIREMENT PLANS

Employees in certified positions participate in the Illinois State Teachers' Retirement System. Payroll withholding of 9.4% is applied to the employee's account, plus .88% is applied to Teachers' Health Insurance Security Fund (THIS). New certified employees also contribute 1.45% to Medicare.

Classified and licensed employees, including COTA/PTA, participated in the Illinois Municipal Retirement Fund (IMRF) and Social Security. Payroll withholding is 12.15% of gross earnings. (4.5% IMRF and 6.2% Social Security (FICA); 1.45% Medicare; 4.5% is tax sheltered).

CREDIT UNIONS

All personnel may call the AAEC 847.392.1922, Monday-Friday 9:00 a.m.-5:00 p.m.; closed Saturday, Sunday, and legal holidays.

Classified personnel may also contact the Metro Federal Credit Union 847.670.0456, Monday-Wednesday 8:00 a.m.-5:00 p.m., Thursday-Friday 8:00 a.m.-5:30 p.m., and Saturday 8:00 a.m.-1:00 p.m.

Both credit unions arrange automatic payroll deductions for convenience in savings and/or repaying loans.

NSSEO GOVERNING BOARD MEETINGS

Board meetings are held on the first Wednesday of each month. Agendas are posted at all building sites. All board meetings are open to the public. All non-tenured staff are required to attend one meeting per school year.

HUMAN RESOURCE OFFICE

The NSSEO Human Resource Office is available to answer questions regarding your employment. Please consider this office a resource. You may contact them at 847.463.8100 with any questions or concerns Monday through Friday 7:30-4:30pm.

WILLIAM HARPER COLLEGE

NSSEO staff members who reside outside the Harper College District are eligible to participate in the Education Service Agreement Program. The staff members must have been employed at NSSEO since the start of the semester. Employment Certification Statements are available in NSSEO program offices and the Human Resource Office. Forms must be authorized by the Director of Human Resources and Instructional Services.

GRADUATE CREDIT

Certified/Licensed

All courses used for advancement on the certified/licensed salary schedule must be applicable to NSSEO employment. No employee shall be denied approval for courses of study leading to general supervisory or general administration (Type 75), psychological or social work (Type 73) certificates or additional special education certification.

Undergraduate courses may be approved for credit advancement on the salary schedule when such courses are specifically applicable to the employee's current assignment. The Superintendent/designee should be contacted regarding approval of the applicability of such coursework. The Superintendent's decision on the acceptability of proposed undergraduate credit shall be final.

Guidelines for Continuing Educations which may be use as Graduate Credit for salary schedule advancement.

1. To be eligible, the seminar or workshop must meet on non-school time and must not be funded with NSSEO travel or grant money.
2. The time spent in the seminar or workshop must have appropriate documentation.
3. Evidence of completion and the amount of instructional time must be submitted by the staff member requesting credit on the Verification of Continuing Education form.
4. A total of 14 instructional hours in documented continuing education will constitute one (1) semester hour to be applied toward advancement on the salary schedule.
5. The Superintendent's decision on the acceptability of proposed seminars/workshops and the validity of documentation shall be final.

Aides

Aides may accrue up to 30 hours of college credit for salary credit. All transcripts must be submitted to the Human Resource Office in order to move to Lane II on the aides' salary schedule.

EDUCATION CREDIT

Evaluation of graduate credits and degrees earned (verified by official transcripts) for proper placement at the start of the school year on the salary schedule shall be completed by December 1st.
Resultant salary adjustments shall be made retroactive to the beginning of the school year.

SUBSTITUTES

Substitutes are provided to cover the absences of classroom teachers. Substitutes for teacher aides are also sometimes available. Teacher aides should check with their program administrator to see if they are to request a substitute when they are absent. Substitutes are available to staff assigned to the following programs:

1. Miner School
2. Kirk School
3. Timber Ridge
4. Riley School

All employees are required to report absences **no later than 7:00 a.m.** of the day of absences. In the event of an employee is unable to report their absence by 7:00 a.m., the employee must then follow program procedures for reporting absence.

AESOP Phone System

1.800.942.3767

All NSSEO staff members are required to use the AESOP attendance system at www.aesoponline.com. Please refer to the AESOP quickstart guide to AESOP online. Employees can also create absences by phone using the AESOP phone system. Refer to the user guide for step by step instructions.

Professional Development Plan

Board of Education

Robert Zimmanck, President	**District 214**
Anna Klimkowicz, Vice President	**District 211**
Kathy Edmonds	**District 21**
Tom Klingner	**District 23**
Daniel Petro	**District 25**
Sue Ramstedt	**District 57**
Barbara Somogyi	**District 59**

Timothy Stoudt, Superintendent
799 West Kensington Road
Mount Prospect, Illinois 60056
847/463-8100

ARTICLE IV
Professional Development

NSSEO Employee Professional Development Plan

4.1 Philosophy Statement

NSSEO believes that professional development empowers individuals to demonstrate their competencies for the betterment of our students. Professional development is a dynamic process which is essential to, and guided by, the aims, values, and beliefs of NSSEO. This process can be multidimensional and should be meaningful and motivating to each individual in his/her pursuit of professional growth.

4.2 Belief Statements

The quality performance of certificated/licensed employees is the keystone of the organization. Therefore, we believe the professional development process:

- supports the mission of the organization and complies with state and federal guidelines;
- must be clearly communicated, understood, and consistently implemented;
- must be manageable in terms of time and resources in order for it to be effective;
- is a collaborative effort between professionals, who share responsibility for its success;
- will be based upon mutually established standards which have been derived from effective teaching practices and organizational expectations;
- leads to the improvement of instruction through effective educational practices;
- includes the documentation and recognition of the individual's achievements so as to generate and reinforce improvement of instruction and positive morale;
- allows for alternative approaches which recognize the needs of a diverse staff,
- is an ongoing process which should be continuously reviewed and evaluated.

* It is understood that the terms educational, instructional, teaching, etc. shall include all instructional, therapeutic and related services employees.

4.3 Orientation

The Professional Development Plan Information will be presented by an NSSEO administrator. The orientation will be given to all NSSEA-covered employees. The orientation will minimally include these subjects:

- Philosophy statement
- Belief statements
- Guidelines
- Expected practices
- Declaration form
- Professional Development Plan Non-probationary Evaluation
- Professional Observation Option Review form
- Professional Development Plan Evaluation Option Review
- Remediation Process

4.54 Professional Development Guidelines

I. Probationary – Years 1- 4

A. Attend informational meeting conducted by Administrator by October 1
Complete two clinical observations annually

1. Scheduled at building level

a. First observation by November 15
b. Second observation by May 1

2. Clinical observation/discourse for each observation

a. Pre-observation conference *(Pre-Observation Worksheet to be completed by the employee prior to each observation)*
b. Post-observation conference *(To be completed and documented within 10 teacher employment days)*

C. Gather Artifact Collection

The collection of artifacts will be mutually agreed upon by employee and Administration and should include, but should not be limited to, the following:

- *Lesson Plans*
- *Student work samples*
- *Examples of assessments documenting student progress*
- *Classroom rules and procedures*
- *Samples of IEPs/written reports*
- *Professional readings*
- *Examples of parent communication*

- *Examples of team planning*

D. Attend a minimum of one NSSEO Governing Board meeting annually

E. Obtain a final summative evaluation report using the Professional Observation Review Form due on or before May 15 from Supervisor

1. *Both formal and informal data which was gathered is used to complete the summative evaluation report.*
2. *The purpose of the summative conference is to document competence in the NSSEO Professional Domain areas.*
3. *An assessment of the employee's performance will be made by checking whether he/she exceeds NSSEO standards, meets NSSEO standards or does not meet NSSEO standards.*
4. *Employees who do not demonstrate competency in 5 or more of the domain sub-categories will not meet NSSEO standards.*
5. *Each sub-category that is unsatisfactory requires written documentation.*

II. **Non-Probationary** (Biennially)

A. Attend informational meeting by October 1

B. "Declaration of Professional Option" due by October 15

1. Professional Development Plan Option

a. Goal(s) must be completed and discussed with administrator by November 15.
b. Completed Professional Development Plan Non-Probationary Evaluation Option to be scheduled, completed and reviewed with administrator by May 15.
c. Evaluation Review (indicating whether or not NSSEO standards are exceeded, met or not met) is to be completed with administrator by May 15.

2. Clinical Observation/Discourse Option

a. Pre-observation conference is required. (*Pre-Observation Worksheet to be completed by the employee prior to observation)*
b. Post-observation conference is required. (*To be completed and documented within work days)*
c. A final summative evaluation report using the Professional Observation Review Form is due on or before May 15th.

i. Both formal and informal data which was gathered is used to complete the summative evaluation report.
ii. The purpose of the summative conference is to document competence in all the NSSEO Professional Domain areas.
iii. Employees who do not meet NSSEO standards will automatically be referred to article 4.9 of the NSSEA Contract.

4.5 Clinical Observation/Discourse Guidelines

- Probationary employees will have their first observation/review completed by November 15, and their second observation/review completed by May 15.
- Non-Probationary employees who declare the observation/discourse option will schedule the observation at the building level and have the observation/discourse completed by May 15.
- An observation will be at least thirty (30) minutes in duration and no longer than one (1) hour, divided over no more than two observation segments.
- Other observation schedules may be determined as appropriate.
- Every effort will be made by the program administrator to observe when scheduled.
- The clinical observation review will be presented to the employee within ten (10) work days of the last scheduled observation or at a later time as agreed upon by both the employee and the Administration.
- The employee shall have the right to submit an explanation or other written statement regarding any review for inclusion in his/her personnel file.
- All clinical observations shall be conducted openly and with full knowledge of the employee.

4.6 Professional Development Plan

- Professional Development Plan review will be scheduled at the building level and completed by May 15.
- When a Non-Probationary employee declares his/her intent to grow professionally through a Professional Development Plan the ~~program~~ Administration will extend all reasonable assistance and support as requested by the employee.
- The employee is responsible for developing and organizing his/her Professional Development Plan.
- The employee will share the outcome(s) of his/her professional growth activities with the Administration.
- Professional Development Plan Non-Probationary Option Plan will be completed by November 15.
- A Conference will be scheduled by November 15 to review and/or develop professional goals.
- Changes to professional goals must be agreed upon by November 30.

4.7 Feedback

1. Positive feedback and support from Administration are essential to enhance professional growth.

2. Feedback is intended to be ongoing communication that can be verbal or written, and should encourage professional growth.

3. Support from Administration could include access to additional resources such as conferences/in-services, monitoring, etc.

4. If the expected practices are not being demonstrated, the Administration may find technical assistance to be warranted. In such cases, the areas needing improvement should be identified at a meeting between the Administration and the employee. The employee has the right to Association representation at this meeting. This technical assistance should be progressive in nature and documented by the ~~program~~ Administration. Efforts to meet the expected practices should also be documented by both parties.

5. Prior to the initiation of a remediation process, the following should have occurred:

   A. Documentation of the technical assistance provided by the Administrator should include the purpose, nature, and frequency of the assistance.
   B. Written feedback should be given to the employee addressing the degree of success of the technical assistance.
   C. A meeting between the Administration and the employee should be held to identify the areas needing improvement.
   D. The employee should be notified in advance of the nature of the meeting and the right to have Association representation at the meeting.

6. Hearsay, unsubstantiated claims, or anonymous communication shall not be part of the evaluation.

7. According to Illinois School Code, 105 ILCS 5/24A-5, section C, NSSEO must evaluate a staff member's performance as excellent, satisfactory or unsatisfactory.

NSSEO Professional Domains

These domain areas are a guideline, not a checklist. They are designed to provide focus for staff self-assessment and goal setting for professional growth.

I. Demonstrates Quality Instructional Practices

A. Plans and implements instruction which meets the diverse needs of learners and helps them to progress both in competence and confidence.
B. Develops appropriate Individualized Educational Plans according to NSSEO guidelines.
C. Demonstrates instructional practices which are appropriate and meaningful for students and reflect IEP goals.
D. Uses varied and innovative teaching strategies, techniques and materials which are appropriate to the needs of the students.
E. Prepares students to function in a community environment.
F. Encourages students to solve problems individually and as members of a team according to their ability.
G. Demonstrates and/or implements assessment strategies to document student progress in appropriate curricular areas.
H. Maintains appropriate and accurate records for each student's progress.
I. Utilizes program curriculum standards and Illinois Learning Standards.
J. Provides opportunities for students to use technology for learning.

II. Demonstrates Continuing Professional Growth

A. Pursues professional growth as an ongoing process.
B. Selects and applies knowledge gained through professional growth.
C. Pursues growth in the area of technology including, but not limited to, computer literacy.

III. Demonstrates Strong Interpersonal Skills and Maintains Effective Professional Relationships with Students, Staff, Parents and Community

A. Is proactive in identifying and providing for each student's needs.
B. Responds to misbehavior appropriately and respects student dignity.
C. Works collaboratively with colleagues in decision making.
D. Participates in creating a positive school climate by fostering supportive and professional relationships.
E. Contributes to the total program effort, as both a leader and supporter.
F. Communicates appropriately and effectively in verbal and written expression.
G. Establishes collaborative relationships with students, staff, parents and community.
H. Maintains confidentiality concerning information about students and their families.

Performance Ratings

Excellent:

- Performance is consistently commendable in all three domain areas.
- Multiple strengths are evidenced in all areas addressed in the Summative Evaluation.
- Commitment is demonstrated to students, parents and program beyond the requirements of the classroom.
- The individual is a self-motivated model of excellence who impacts and relates positively to students, parents, staff and school environment.

Satisfactory:

- Proficiency is demonstrated in all three domain areas.
- Demonstrates strengths evidenced in some areas addressed in the Summative Evaluation.
- Displays adequate competency and produces what can reasonably be expected of an NSSEO staff member.
- Improvement may be designed by the staff member or through the implementation of a growth plan.

Unsatisfactory:

- Performance is poor.
- Documented observations reveal significant weaknesses in 5 or more NSSEO Professional domain sub-areas addressed in the Summative Evaluation.
- Professional behavior is below the level of acceptability.
- Improvement is mandatory, and remediation is required.

Tenured Professional Development Plan
Instructions

The Professional Development Plan begins with a self-evaluation that results in the completion of the Professional Development Plan Tenure Option Form. Staff members will conference with their administrator prior to November 15 to review their goal(s). Staff members may have completed their goal(s) setting prior to the conference or may develop the goal(s) with their administrator during the conference. Staff members will use the NSSEO Professional Domains when completing their Professional Development Plan.

Staff members are required to show growth in the three domain areas:

I. Demonstrates Quality Instructional Practices
II. Demonstrates Continuing Professional Growth
III. Demonstrates Strong Interpersonal Skills and Maintains Effective Professional Relationships with Students, Staff, Parents and Community

A minimum of two conference sessions between the staff member and the administrator are required. The first session is the goal setting conference and the last conference is the final evaluation conference. If the administrator and staff member do not agree on the Professional Development Plan, an observation will be required. Any changes to the Professional Development Plan need to be agreed upon by staff member and administrator. A Professional Development Plan Evaluation Review must be completed and signed by the administrator and staff member. An assessment of the staff member's performance will be made by checking whether he/she exceeds NSSEO standards, meets NSSEO standards, or does not meet NSSEO standards.

Indicators of progress toward achieving the identified goal(s) may include: student work portfolios, peer observations, administrator observation, parent and/or student feedback, statistical measures, performance assessment, reflective journals, case study analysis, benchmarks, anecdotal records, best practice, etc.

The Evaluation Review Form must be completed and reviewed with staff members by May 15. Any staff member who does not meet NSSEO standards is Referred to Article 4.9 of the NSSEA Contract, (Remediation Plan).

DECLARATION OF PROFESSIONAL DEVELOPMENT OPTION
(Tenured Staff)

School Year

Name: _____

Program: _____

Position: _____

_____ Professional Development Plan
_____ Clinical Observation

_____ _____
Staff Signature Date

_____ _____
Supervisor Signature Date

To be completed and submitted to program administrator by October 15.

Professional Development Plan
Tenure Evaluation Option
(To be completed by Staff Member)

NSSEO is committed to professional development in the following domains: *1.) Demonstrates Quality Instructional Practices, 2.) Demonstrates Continuing Professional Growth, and 3.) Demonstrates Strong Interpersonal Skills and Maintains Effective Professional Relationships with Students, Staff, Parents and Community.*

Name: Program:

Position: School Year:

I. Indicate goal(s) that will be addressed in your Professional Development Plan this year. (*complete by November 15th*)

II. Reflect on how your professional development goal(s) support the three NSSEO domain areas. (*to be completed by May 15th*)

1. Demonstrates Quality Instruction Practices

2. Demonstrates Continuing Professional Growth

3. Demonstrates Strong Interpersonal Skills and Maintains Effective Professional Relationships with Students, Staff, Parents and Community

III. What are future considerations?

Professional Development Plan
Evaluation Review
(To be completed by Administrator)

I. Administrator's Comments:

II. Performance Rating:

☐ Exceeds NSSEO Standards (Excellent)

☐ Meets NSSEO Standards (Satisfactory)

☐ Does Not Meet NSSEO Standards (Unsatisfactory) *

III. Professional Development Plan was reviewed and discussed on _____
Date

_____ _____
Staff Signature Supervisor's Signature

Staff member's signature does not necessarily indicate agreement with report. (A written response may also be attached or sent to the Personnel Office within thirty working days).

* Unsatisfactory performance rating initiates the remediation process as outlined in Article 4.9 of the NSSEA contract.

NSSEA Contract

The current NSSEA Contract was approved by the NSSEO Governing Board on December 7, 2011. To view and print your copy of the contract click on the link www.nsseo.org click on Admin Center then Human Resources.

Building a promising future for students

NSSEO

Northwest Suburban Special Education Organization

Important NSSEO Polices and Guidelines

5:20

Personnel

Workplace Harassment Prohibited

NSSEO expects the workplace environment to be productive, respectful, and free of unlawful harassment. NSSEO employees shall not engage in harassment or abusive conduct on the basis of an individual's race, religion, national origin, sex, sexual orientation, age, citizenship status, disability, or other protected status identified in Board policy 5:10, *Equal Employment Opportunity and Minority Recruitment*. Harassment of students, including, but not limited to, sexual harassment, is prohibited by Board policy 7:20, *Harassment of Students Prohibited*.

Sexual Harassment Prohibited

NSSEO shall provide a workplace environment free of unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct, or communications constituting harassment on the basis of sex as defined and otherwise prohibited by State and federal law.

NSSEO employees shall not make unwelcome sexual advances or request sexual favors or engage in any unwelcome conduct of a sexual nature when: (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment; (2) submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual; or (3) such conduct has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment. Sexual harassment prohibited by this policy includes verbal or physical conduct. The terms intimidating, hostile, or offensive include, but are not limited to, conduct that has the effect of humiliation, embarrassment, or discomfort. Sexual harassment will be evaluated in light of all the circumstances.

Making a Complaint: Enforcement

A violation of this policy may result in discipline, up to and including discharge. Any person making a knowingly false accusation regarding harassment will likewise be subject to disciplinary action, up to and including discharge. An employee's employment, compensation, or work assignment shall not be adversely affected by complaining or providing information about harassment. Retaliation against employees for bringing bona fide complaints or providing information about harassment is prohibited (see Board policy 2:260, *Uniform Grievance Procedure*).

Aggrieved persons, who feel comfortable doing so, should directly inform the person engaging in harassing conduct or communication that such conduct or communication is offensive and must stop.

Employees should report claims of harassment to the Nondiscrimination Coordinator and/or use Board policy 2:260, *Uniform Grievance Procedure*. Employees may choose to report to a person of the employee's same sex. There are no express time limits for initiating complaints and grievances under this policy; however, every effort should be made to file such complaints as soon as possible, while facts are known and potential witnesses are available.

Whom to Contact with a Report or Complaint

The Superintendent shall insert into this policy the names, addresses, and telephone numbers of the NSSEO's current Nondiscrimination Coordinator and Complaint Managers.

Nondiscrimination Coordinator:

Cathy Kostecki
Name
799 W. Kensington Rd.
Address
Mount Prospect, IL 60056

847.463.8100
Telephone

Complaint Managers:

Cathy Kostecki	Hassan von Schlegell
Name	Name
799 W. Kensington Rd.	201 S. Evanston Avenue
Address	Address
Mount Prospect, IL 60056	Arlington Heights, IL 60004
847.463.8100	847.463.8300
Telephone	Telephone

The Superintendent shall also use reasonable measures to inform staff members and applicants for employment of this policy, which shall include reprinting this policy in the appropriate handbooks.

LEGAL REF.: Title VII of the Civil Rights Act, 42 U.S.C. §2000e et seq., 29 C.F.R. §1604.11.
Title IX of the Education Amendments, 20 U.S.C. §1681 et seq.; 34 C.F.R. §1604.11.
Ill. Human Rights Act, 775 ILCS 5/2-101(E), 5/2-102(D), 5/5-102, and 5/5-102.2.
56 Ill. Admin.Code Parts 2500, 2510, 5210, and 5220.
Burlington Industries v. Ellerth, 118 S.Ct. 2257 (1998).
Faragher v. City of Boca Raton, 118 S.Ct. 2275 (1998).
Franklin v. Gwinnett Co. Public Schools, 112 S.Ct. 1028 (1992).
Harris v. Forklift Systems, 114 S.Ct. 367 (1993).
Jackson v. Birmingham Board of Education, 125 S.Ct. 1497 (2005).
Meritor Savings Bank v. Vinson, 106 S.Ct. 2399 (1986).
Oncale v. Sundown Offshore Services, 118 S.Ct. 998 (1998).
Porter v. Erie Foods International, Inc., 576 F.3d 629 (7th Cir. 2009).
Sangamon County Sheriff's Dept. v. Ill. Human Rights Com'n, 908 N.E.2d 39 (Ill., 2009).

CROSS REF.: 2:260 (Uniform Grievance Procedure), 5:10 (Equal Employment Opportunity and Minority Recruitment), 7:20 (Harassment of Students Prohibited)

ADOPTED: January 5, 2011

5:50

Personnel

Drug- and Alcohol-Free Workplace

All NSSEO workplaces are drug- and alcohol-free workplaces. All employees shall be prohibited from:

1. Unlawful manufacture, dispensing, distribution, possession, use, or being under the influence of a controlled substance while on NSSEO premises or while performing work for the Organization, and
2. Distribution, consumption, use, possession, or being under the influence of alcohol while on NSSEO premises or while performing work for the Organization.

For purposes of this policy a controlled substance means a substance that is:

1. Not legally obtainable,
2. Being used in a manner different than prescribed,
3. Legally obtainable, but has not been legally obtained, or
4. Referenced in federal or State controlled substance acts.

As a condition of employment, each employee shall:

1. Abide by the terms of the NSSEO policy respecting a drug- and alcohol-free workplace; and
2. Notify his or her supervisor of his or her conviction under any criminal drug statute for a violation occurring on the NSSEO premises or while performing work for the Organization, no later than 5 calendar days after such a conviction.

In order to make employees aware of dangers of drug and alcohol abuse, the NSSEO will:

1. Provide each employee with a copy of the NSSEO Drug- and Alcohol-Free Workplace policy;
2. Post notice of the NSSEO Drug- and Alcohol-Free Workplace policy in a place where other information for employees is posted;
3. Make available materials from local, State, and national anti-drug and alcohol-abuse organizations;
4. Enlist the aid of community and State agencies with drug and alcohol informational and rehabilitation programs to provide information to Organization employees;
5. Establish a drug-free awareness program to inform employees about:
   a. The dangers of drug abuse in the workplace,
   b. Available drug and alcohol counseling, rehabilitation, re-entry, and any employee assistance programs, and
   c. The penalties that the NSSEO may impose upon employees for violations of this policy.

NSSEO Action Upon Violation of Policy

An employee who violates this policy may be subject to disciplinary action, including termination. Alternatively, the Governing Board may require an employee to successfully complete an appropriate drug- or alcohol-abuse, employee-assistance rehabilitation program.

The Board shall take disciplinary action with respect to an employee convicted of a drug offense in the workplace within 30 days after receiving notice of the conviction.

Should NSSEO employees be engaged in the performance of work under a federal contract or grant, or under a State contract or grant of $5,000 or more, the Superintendent shall notify the appropriate State or federal agency from which the NSSEO receives contract or grant monies of the employee's conviction within 10 days after receiving notice of the conviction.

LEGAL REF.: Americans With Disabilities Act, 42 U.S.C. §12114.
Controlled Substances Act, 21 U.S.C. §812; 21 C.F.R. §1308.11-1308.15.
Drug-Free Workplace Act of 1988, 41 U.S.C. §701 et seq.
Safe and Drug-Free School and Communities Act of 1994, 20 U.S.C. §7101 et seq.
Drug-Free Workplace Act, 30 ILCS 580/1 et seq.

ADOPTED: September 2, 2009

Personnel

5:90

Abused and Neglected Child Reporting

Any NSSEO employee who suspects or receives knowledge that a student may be an abused or neglected child or, for a student aged 18 through 21, an abused or neglected individual with a disability, shall immediately: (1) report such a case to the Illinois Department of Children and Family Services on its Child Abuse Hotline 800/25-ABUSE or 217/524-2606, and (2) follow any additional directions given by the Illinois Department of Children and Family Services to complete a report.. The employee shall also promptly notify the Superintendent or supervisor that a report has been made. All NSSEO employees shall sign the *Acknowledgement of Mandated Reporter Status* form provided by the Illinois Department of Child and Family Services (DCFS) and the Superintendent or designee shall ensure that the signed forms are retained.

Any NSSEO employee who discovers child pornography on electronic and information technology equipment shall immediately report it to local law enforcement, the National Center for Missing and Exploited Children's CyberTipline 800/843-5678, or online at www.cybertipline.com. The Superintendent or Building Principal shall also be promptly notified of the discovery and that a report has been made.

The Superintendent shall execute the requirements in Board policy 5:150, *Personnel Records*, whenever another district or organization requests a reference concerning an applicant who is or was an NSSEO employee and was the subject of a report made by an NSSEO employee to DCFS.

The Superintendent shall notify the State Superintendent and the Regional Superintendent in writing when he or she has reasonable cause to believe that a certificate holder was dismissed or resigned from the Organization as a result of an act that made a child an abused or neglected child. The Superintendent must make the report within 30 days of the dismissal or resignation and mail a copy of the notification to the certificate holder.

The Superintendent or designee shall provide staff development opportunities for school personnel working with students in grades kindergarten through 8, in the detection, reporting, and prevention of child abuse and neglect.

Each individual Board member must, if an allegation is raised to the member during an open or closed Board meeting that a student is an abused child as defined in the Act, direct or cause the Board to direct the Superintendent or other equivalent school administrator to comply with the Act's requirements concerning the reporting of child abuse.

LEGAL REF.: 105 ILCS 5/10-21.9.
20 ILCS 1305/1-1 et seq.
20 ILCS 2435/.
325 ILCS 5/.

CROSS REF.: 2:20 (Powers and Duties of the Board), 5:20 (Workplace Harassment Prohibited), 5:100 (Professional Development Program), 5:150 (Personnel Records), 6:120 (Education of Children with Disabilities), 7:20 (Harassment of Students Prohibited), 7:150 (Agency and Police Interviews), 8:100 (Relationships with Other Organizations and Agencies)

ADOPTED: January 5, 2011

NewEmpOrient/PolicyLet/590
8/11

5:200

Professional Personnel

Terms and Conditions of Employment and Dismissal

The Governing Board delegates authority and responsibility to the Superintendent to manage the terms and conditions for the employment of professional personnel. The Superintendent shall act reasonably and comply with State and federal law as well as any applicable collective bargaining agreement in effect. The Superintendent is responsible for making dismissal recommendations to the Board consistent with the Board's goal of having a highly qualified, high performing staff.

School Year and Day

Please refer to the current Contract Agreement between the Governing Board of the NSSEO, Northwest Suburban Special Education Organization and the NSSEA, Northwest Suburban Special Education Association, IEA – NEA.

For those employees not covered by this Agreement:

Certified/licensed staff shall work according to the school calendar adopted by the Board, which shall have a minimum of 176 student attendance days and a minimum of 180 work days, including institute days.

Certified/licensed staff are required to work the school day adopted by the Board. The NSSEO accommodates employees who are nursing mothers according to provisions in the Nursing Mothers in the Workplace Act.

Salary

Please refer to the current Contract Agreement between the Governing Board of the NSSEO, Northwest Suburban Special Education Organization and the NSSEA, Northwest Suburban Special Education Association, IEA – NEA.

For those employees not covered by this Agreement:

Certified/licensed staff shall be paid according to the salary schedule adopted by the Board, but in no case less than the minimum salary provided by The School Code. Staff shall be paid at least monthly on a 24 pay period basis.

Assignments and Transfers

Please refer to the current Contract Agreement between the Governing Board of the NSSEO, Northwest Suburban Special Education Organization and the NSSEA, Northwest Suburban Special Education Association, IEA – NEA.

For those employees not covered by this Agreement:

The Superintendent is authorized to make extra duty assignments. In order of priority, assignments shall be made based on the NSSEO's needs and best interests, employee qualifications, and employee desires.

Duty-Free Lunch

Staff employed for at least 4 hours per day shall receive a duty-free lunch equivalent to the student lunch period, or 30 minutes, whichever is longer.

Evaluation

Please refer to the current Contract Agreement between the Governing Board of the NSSEO, Northwest Suburban Special Education Organization and the NSSEA, Northwest Suburban Special Education Association, IEA – NEA.

For those employees not covered by this Agreement:

The NSSEO's evaluation plan will be conducted in compliance with The School Code.

Dismissal

Please refer to the current Contract Agreement between the Governing Board of the NSSEO, Northwest Suburban Special Education Organization and the NSSEA, Northwest Suburban Special Education Association, IEA – NEA.

For those employees not covered by this Agreement:

The NSSEO will follow State law when dismissing a certified or licensed employee.

LEGAL REF.: 105 ILCS 5/10-19, 5/18-8, 5/24-2, 5/24-8, 5/24-9, 5/24-21, 5/24A-4, and 5/24A-5.
820 ILCS 260/1 et seq.
Cleveland Board of Education v. Loudermill, 105 S.Ct. 1487(1985).

CROSS REF.: 5:290 (Employment Termination and Suspensions)

ADOPTED: September 2, 2009

5:240

Professional Personnel

Suspension

Suspension Without Pay

The Superintendent or his or her designee may suspend a professional employee (for up to 5 employment days) without pay for misconduct that is detrimental to NSSEO. The Board may suspend without pay: (1) a professional employee pending a dismissal hearing, or (2) a professional employee as a disciplinary measure for misconduct that is detrimental to the NSSEO. Administrative staff members may not be suspended without pay as a disciplinary measure.

Misconduct that is detrimental to the NSSEO includes:

- Insubordination, including any failure to follow an oral or written directive from a supervisor;
- Violation of Board policy or Administrative Procedure;
- Conduct that disrupts or may disrupt the educational program or process;
- Conduct that violates any State or federal law that relates to the employee's duties; and
- Other sufficient causes.

Prior to a suspension without pay, the employee will be notified of the charges by the Superintendent or designee and have an opportunity to explain or rebut the charges at a meeting with the Superintendent or designee. The employee will be provided with a written notice of suspension.

The employee may request a hearing to appeal the suspension without pay within five (5) days after receiving the notice of suspension. In the event of an appeal, the suspension will be implemented pending the appeal at the discretion of the Superintendent. The Board or hearing officer will conduct the hearing. The Board or its designee shall notify the professional employee of the alleged charges and the date and time of the hearing. The hearing will be conducted in accordance with procedures adopted by the Board.

Suspension With Pay

The Board or Superintendent or designee may suspend a professional employee with pay: (1) during an investigation into allegations of disobedience or misconduct whenever the employee's continued presence in his or her position would not be in the NSSEO's best interests, (2) as a disciplinary measure for misconduct that is detrimental to the NSSEO, or (3) pending a hearing before the Board or a hearing officer to consider further discipline, including dismissal from employment.

The Superintendent shall meet with the employee to present the allegations and give the employee an opportunity to refute the charges. The employee will be told the dates and times the suspension will begin and end.

LEGAL REF.: 5 ILCS 430 et seq.
105 ILCS 5/24-12.
Cleveland Board of Education v. Loudermill, 105 S.Ct. 1487 (1985).
Barszcz v. Community College District No. 504, 400 F.Supp. 675 (N.D. Ill., 1975).
Massie v. East St. Louis School District No.189, 561 N.E.2d 246 (Ill.App.5, 1990).

CROSS REF.: 5:290 (Educational Support Personnel - Employment Termination and Suspensions)

ADOPTED: September 2, 2009

NSSEO FAMILY MEDICAL LEAVE

Eligibility:

- Employees are eligible who have been employed for 1,250 hours during the 12 month period preceding the start of the Family Medical Leave (FML).

Procedure:

- Thirty (30) days written notice; to the Director of Human Resources and Instructional Services; requesting leaves when foreseeable.

- An employee may request FML for the following reasons:

  1. the birth of a child and to care for the newborn child;
  2. the adoption of a child or the placement of a foster child;
  3. to care for a spouse, son, daughter, parent, etc. who has a serious health condition; or
  4. a serious health condition that makes the employee unable to perform the functions of his/her job.

- An FML is paid as long as the employee has **sick leave** to cover the leave. Medical and dental insurance for the employee only will continue during the leave. The employee must make payments for dependent coverage.

- If employee meets the eligibility criteria the FML is up to 12 weeks (60 work days).

Medical Certification:

- Medical certification may be required to support the leave and a release to return to work is required.

799 West Kensington Rd., Mount Prospect, IL 60056-1111 ● Ph: 847.463.8100 • Fax 847.463.8121 ● TDD: 847.463.8115 ● www.nsseo.org

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

Instruction 6.50

School Wellness

Belief Statement

The Northwest Suburban Special Education Organization (NSSEO) is committed to providing a learning environment that supports and promotes wellness, good nutrition, and an active lifestyle and recognizes the positive relationship between good nutrition, physical activity and the capacity of students to develop and learn. School staff is encouraged to model healthy eating and physical activity as a valuable part of daily life.

Intent

The purpose of this policy is to ensure a total school environment that promotes and supports student health and wellness, helps to reduce childhood obesity and meets the requirements of the Child Nutrition and WIC Reauthorization Act of 2004 and the Illinois School Code. In order to meet these requirements, standards focus on goals for nutrition education, physical activity and other school-based activities. Procedures for implementing this policy shall promote student wellness, adhere to nutrition guidelines for all foods available during the school day, and provide a plan for measuring implementation.

Goals for Nutrition Education

The nutrition education curriculum shall align with the Illinois Learning Standards and shall foster the positive relationship between good nutrition, physical activity and the capacity of students to develop and learn.

Nutrition education shall be integrated into the standards-based lessons of several academic areas including math, science, language arts, physical education, health, family and consumer sciences, as appropriate to the student.

Good nutrition for students shall be promoted in the classroom, on field trips, in the lunchroom and during after school events.

Goals for Physical Activity

The NSSEO schools shall promote daily physical activity that is beneficial to students and within each student's level of capability.

The physical education curriculum shall be integrated into other academic areas as appropriate including mathematics, science, language arts, social studies, nutrition education and health education.

The physical education curriculum shall include health-related fitness concepts, individual activities, and competitive team sports, as students are able to participate, and a variety of student activities that encourage life-long physical activity.

School personnel shall not withhold physical education classes or recess for reasons other than a student's health and safety, unless otherwise provided in an individual student's IEP.

Nutrition Guidelines for All Foods and Beverages Available in School During the School Day

Snacks brought in by students, parents, or teachers as well as snacks served during the school day shall make a positive contribution to students' diet and health. Emphasis shall be placed on serving fruits and vegetables as the primary snacks and water as the primary beverage.

Foods made available in school shall comply with the current USDA Dietary Guidelines for Americans: vending machines, a la carte, fundraisers, student stores, school parties/celebrations.

Parents, teachers, students (as appropriate) and school officials are encouraged to participate in selecting food for their schools.

Food service shall restrict the sale of foods of minimal nutritional value as defined by the U.S. Department of Agriculture.

Guidelines for Reimbursable School Meals

School meals served to students shall be consistent with recommendations of the Dietary Guidelines for Americans and the nutrition requirements for the National School Lunch Program.

Menus shall be planned using the food-based menu planning approaches based on meal patterns that contain four food components in the specified minimum amounts for various age/grades of students.

For lunches, five food items shall be offered in the specified amounts. These are: meat/meat alternate, grains/breads, two servings of vegetables/fruits, and milk.

Implementation and Monitoring

The Superintendent or designee shall provide periodic implementation data and/or reports to the Governing Board concerning the implementation of this policy such that the Board may monitor the policy and make changes as necessary.

Community Input

The Superintendent or designee shall encourage the input of parents, students, and representatives of the school food authority, the Board, school administrators, and the public in the implementation and review of this policy.

LEGAL REF.: Child Nutrition and WIC Reauthorization Act of 2004, PL 108-265, Sec. 204.
Child Nutrition Act of 1966, 42 U.S.C. §1771 et seq.
National School Lunch Act, 42 U.S.C. §1758.
42 U.S.C. §1779, as implemented by 7 C.F.R. §210.11.
105 ILCS 5/2-3.~~137~~139.
23 Ill.Admin.Code Part 305, Food Program.
ISBE's "School Wellness Policy" Goal, adopted Oct. 2007.

CROSS REF.: 4:120 (Food Services)

ADOPTED: September 2, 2009

7:10

Students

Equal Educational Opportunities

Equal educational and extracurricular opportunities shall be available for all students without regard to color, race, nationality, religion, sex, sexual orientation, ancestry, age, physical or mental disability, gender identity, status of being homeless, order of protection status, actual or potential marital or parental status, including pregnancy or other protected group status. Further, NSSEO will not knowingly enter into agreements with any entity or any individual that discriminates against students on the basis of sex or any other protected group status, except that NSSEO remains viewpoint neutral when granting access to school facilities under Board policy 8:20, *Community Use of School Facilities*. Any student may file a discrimination grievance by using Board policy 2:260, *Uniform Grievance Procedure*.

Sex Equity

No student shall, based on sex, sexual orientation, or gender identity be denied equal access to programs, activities, services, or benefits or be limited in the exercise of any right, privilege, advantage, or denied equal access to educational and extracurricular programs and activities.

Any student may file a sex equity complaint by using Board policy 2:260, *Uniform Grievance Procedure*. A student may appeal the Board's resolution of the complaint to the appropriate Intermediate Center (pursuant to 105 ILCS 5/3-10) and, thereafter, to the State Superintendent of Education (pursuant to 105 ILCS 5/2-3.8).

Administrative Implementation

The Superintendent shall appoint a Nondiscrimination Coordinator. The Superintendent and Building Principal shall use reasonable measures to inform staff members and students of this policy and grievance procedure.

LEGAL REF.: 42 U.S.C. §11431 et seq., McKinney Homeless Assistance Act.
20 U.S.C. §1681 et seq., 34 C.F.R. Part 106, Title IX of the Educational Amendments.
29 U.S.C. §791 et seq., Rehabilitation Act of 1973.
775 ILCS 35/5, Religious Freedom Restoration Act.
Ill. Constitution, Art. I, §18.
Good News Club v. Milford Central School, 121 S.Ct. 2093 (2001).
105 ILCS 5/3.25b, 3.25d(b), 10-20.12, 10-22.5, and 27-1.
775 ILCS 5/1-101 et seq; Illinois Human Rights Act.
23 Ill.Admin.Code §1.240 and Part 200.

CROSS REF.: 2:260 (Uniform Grievance Procedure), 6:220 (Instructional Materials Selection and Adoption), 7:20 (Harassment of Students Prohibited), 7:130 (Student Rights and Responsibilities), 7:330 (Student Use of Buildings - Equal Access), 8:20 (Community Use of School Facilities)

ADOPTED: January 5, 2011

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7:15

Students

Student and Family Privacy Rights

Surveys

All surveys requesting personal information from students, as well as any other instrument used to collect personal information from students, must advance or relate to NSSEO's educational objectives as identified in Board policy 6:10, *Educational Philosophy and Objectives*, or assist students' career choices. This applies to all surveys, regardless of whether the student answering the questions can be identified and regardless of who created the survey.

Surveys Created by a Third Party

Before a school official or staff member administers or distributes a survey or evaluation created by a third party to a student, the student's parent(s)/guardian(s) may inspect the survey or evaluation, upon their request and within a reasonable time of their request.

This section applies to every survey: (1) that is created by a person or entity other than a NSSEO official, staff member, or student, (2) regardless of whether the student answering the questions can be identified, and (3) regardless of the subject matter of the questions.

Survey Requesting Personal Information

School officials and staff members shall not request, nor disclose, the identity of any student who completes any survey or evaluation (created by any person or entity, including NSSEO) containing one or more of the following items:

1. Political affiliations or beliefs of the student or the student's parent/guardian.
2. Mental or psychological problems of the student or the student's family.
3. Behavior or attitudes about sex.
4. Illegal, anti-social, self-incriminating, or demeaning behavior.
5. Critical appraisals of other individuals with whom students have close family relationships.
6. Legally recognized privileged or analogous relationships, such as those with lawyers, physicians, and ministers.
7. Religious practices, affiliations, or beliefs of the student or the student's parent/guardian.
8. Income other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program.

The student's parent(s)/guardian(s) may:

1. Inspect the survey or evaluation upon, and within a reasonable time of, their request, and/or
2. Refuse to allow their child or ward to participate in the activity described above. The school shall not penalize any student whose parent(s)/guardian(s) exercised this option.

Instructional Material

A student's parent(s)/guardian(s) may inspect, upon their request, any instructional material used as part of their child/ward's educational curriculum within a reasonable time of their request.

The term "instructional material" means instructional content that is provided to a student, regardless of its format, printed or representational materials, audio-visual materials, and materials in electronic or digital formats (such as materials accessible through the Internet). The term does not include academic tests or academic assessments.

Physical Exams or Screenings

No school official or staff member shall subject a student to a non-emergency, invasive physical examination or screening as a condition of school attendance. The term "invasive physical examination" means any medical examination that involves the exposure of private body parts, or any act during such examination that includes incision, insertion, or injection into the body, but does not include a hearing, vision, or scoliosis screening.

The above paragraph does not apply to any physical examination or screening that:

1. Is permitted or required by an applicable State law, including physical examinations or screenings that are permitted without parental notification.
2. Is administered to a student in accordance with the Individuals with Disabilities Education Act (20 U.S.C. §1400 et seq.).
3. Is otherwise authorized by Board policy.

Selling or Marketing Students' Personal Information Is Prohibited

No school official or staff member shall market or sell personal information concerning students (or otherwise provide that information to others for that purpose). The term "personal information" means individually identifiable information including: (1) a student or parent's first and last name, (2) a home or other physical address (including street name and the name of the city or town), (3) a telephone number, (4) a Social Security identification number or (5) driver's license number or State identification card.

The above paragraph does not apply: (1) if the student's parent(s)/guardian(s) have consented; or (2) to the collection, disclosure or, use of personal information collected from students for the exclusive purpose of developing, evaluating or providing educational products or services for, or to, students or educational institutions, such as the following:

1. College or other postsecondary education recruitment, or military recruitment.
2. Book clubs, magazines, and programs providing access to low-cost literary products.
3. Curriculum and instructional materials used by elementary schools and secondary schools.
4. Tests and assessments to provide cognitive, evaluative, diagnostic, clinical, aptitude, or achievement information about students (or to generate other statistically useful data for the purpose of securing such tests and assessments) and the subsequent analysis and public release of the aggregate data from such tests and assessments.
5. The sale by students of products or services to raise funds for school-related or education-related activities.
6. Student recognition programs.

Under no circumstances may a school official or staff member provide a student's "personal information" to a business organization or financial institution that issues credit or debit cards.

Notification of Rights and Procedures

The Superintendent or designee shall notify students' parents/guardians of:

1. This policy as well as its availability upon request from the general administration office.
2. How to opt their child or ward out of participation in activities as provided in this policy.
3. The approximate dates during the school year when a survey requesting personal information, as described above, is scheduled or expected to be scheduled.
4. How to request access to any survey or other material described in this policy.

This notification shall be given parents/guardians at least annually, at the beginning of the school year, and within a reasonable period after any substantive change in this policy.

The rights provided to parents/guardians in this policy transfer to the student when the student turns 18 years old, or is an emancipated minor.

The right provided to parents/guardians in this policy transfer to the student when the student turns 18 years old, or is an emancipated minor.

LEGAL REF: Protection of Pupil Rights, 20 U.S.C. § 123h.
Children's Privacy Protection and Parental Empowerment Act, 325 ILCS 17/1 et seq.
105 ILCS 5/10-20.38.

CROSS REF: 2:260 (Uniform Grievance Procedure), 6:210 (Instructional Materials), 6:260(Complaints About Curriculum, Instructional Materials, and Programs), 7:130 (Students Rights and Responsibilities)

ADOPTED: September 2, 2009

Students 7:20

Harassment of Students Prohibited

Bullying, Intimidation, and Harassment Prohibited

No person, including an NSSEO employee or agent, or student, shall harass, intimidate, or bully a student on the basis of actual or perceived: race; color; nationality; sex; sexual orientation; gender identity; gender-related identity or expression; ancestry; age; religion; physical or mental disability; order of protection status; status of being homeless; actual or potential marital or parental status, including pregnancy; association with a person or group with one or more of the aforementioned actual or perceived characteristics; or any other distinguishing characteristic. NSSEO will not tolerate harassing, intimidating conduct, or bullying whether verbal, physical, or visual, that affects the tangible benefits of education, that unreasonably interferes with a student's educational performance, or that creates an intimidating, hostile, or offensive educational environment. Examples of prohibited conduct include name-calling, using derogatory slurs, stalking, causing psychological harm, threatening or causing physical harm, threatened or actual destruction of property, or wearing or possessing items depicting or implying hatred or prejudice of one of the characteristics stated above.

Sexual Harassment Prohibited

Sexual harassment of students is prohibited. Any person, including a NSSEO employee or agent, or student, engages in sexual harassment whenever he or she makes sexual advances, requests sexual favors, and engages in other verbal or physical conduct of a sexual or sex-based nature, imposed on the basis of sex, that:

1. Denies or limits the provision of educational aid, benefits, services, or treatment; or that makes such conduct a condition of a student's academic status; or
2. Has the purpose or effect of:
   a. Substantially interfering with a student's educational environment;
   b. Creating an intimidating, hostile, or offensive educational environment;
   c. Depriving a student of educational aid, benefits, services, or treatment; or
   d. Making submission to or rejection of such conduct the basis for academic decisions affecting a student.

The terms "intimidating," "hostile," and "offensive" include conduct that has the effect of humiliation, embarrassment, or discomfort. Examples of sexual harassment include touching, crude jokes or pictures, discussions of sexual experiences, teasing related to sexual characteristics, and spreading rumors related to a person's alleged sexual activities.

Making a Complaint; Enforcement

Students are encouraged to report claims or incidences of bullying, harassment, sexual harassment, or any other prohibited conduct to the student Nondiscrimination Coordinator, Building Principal, Assistant Building Principal, or a Complaint Manager. Students may choose to report to a person of the student's same sex. Complaints will be kept confidential to the extent possible given the need to investigate. A student who make good faith complaints will not be disciplined.

An allegation that a student was a victim of any prohibited conduct perpetrated Building Principal, or Assistant Building Principal for appropriate action.

The Superintendent shall insert into this policy the names, addresses, and telephone numbers of NSSEO's current Nondiscrimination Coordinator and Complaint Managers. At least one of these individuals will be female, and at least one will be male.

Nondiscrimination Coordinator:

Cathy Kostecki
Name
799 W. Kensington Rd.
Address
Mount Prospect, IL 60056

847.463.8100
Telephone

Complaint Managers:

Cathy Kostecki	Hassan von Schlegell
Name	Name
799 W. Kensington Rd.	201 S. Evanston Avenue
Address	Address
Mount Prospect, IL 60056	Arlington Heights, IL 60004
847.463.8100	847.463.8300
Telephone	Telephone

The Superintendent shall use reasonable measures to inform staff members and students of this policy, such as, by including it in the appropriate handbooks.

Any NSSEO employee who is determined, after an investigation, to have engaged in conduct prohibited by this policy will be subject to disciplinary action up to and including discharge. Any NSSEO student who is determined, after an investigation, to have engaged in conduct prohibited by this policy will be subject to disciplinary action, including but not limited to, suspension and expulsion consistent with the discipline policy. Any person making a knowingly false accusation regarding prohibited conduct will likewise be subject to disciplinary action up to and including discharge, with regard to employees, or suspension and expulsion, with regard to students.

LEGAL REF.: 20 U.S.C. §1681 et seq., Title IX of the Educational Amendments.
34 C.F.R. Part 106.
105 ILCS 5/10-20.12, 10-22.5, 5/27-1, and 5/27-23.7.
775 ILCS 5/1-101 et seq., Illinois Human Rights Act.
23 Ill.Admin.Code §1.240 and Part 200.
Davis v. Monroe County Board of Education, 119 S.Ct. 1661 (1999).
Franklin v. Gwinnett Co. Public Schools, 112 S.Ct. 1028 (1992).
Gebser v. Lago Vista Independent School District, 118 S.Ct. 1989 (1998).
West v. Derby Unified School District No. 260, 206 F.3d 1358 (10th Cir., 2000).

CROSS REF.: 2:260 (Uniform Grievance Procedure), 5:20 (Workplace Harassment Prohibited), 7:10 (Equal Educational Opportunities), 7:180 (Preventing Bullying, Intimidation, and Harassment), 7:190 (Student Discipline)

ADOPTED: January 5, 2011

Students 7:285

Food Allergy Management Program

School attendance may increase a student's risk of exposure to allergens that could trigger a food-allergic reaction. A food allergy is an adverse reaction to a food protein mediated by the immune system which immediately reacts causing the release of histamine and other inflammatory chemicals and mediators. While it is not possible for NSSEO to completely eliminate the risks of exposure to allergens when a student is at school, a Food Allergy Management Program using a cooperative effort among students' families, staff members, and students helps NSSEO reduce these risks and provide accommodations and proper treatment for allergic reactions.

The Superintendent or designee shall develop and implement a Food Allergy Management Program that:

1. Fully implements the following goals established in The School Code: (a) identifying students with food allergies, (b) preventing exposure to known allergens, (c) responding to allergic reactions with prompt recognition of symptoms and treatment, and (d) educating and training all staff about management of students with food allergies, including administration of medication with an auto-injector, and providing an in-service training program for staff who work with students that is conducted by a person with expertise in anaphylactic reactions and management.
2. Follows and references the applicable best practices specific to NSSEO's needs in the joint State Board of Education and Ill. Dept. of Public Health publication *Guidelines for Managing Life-Threatening Food Allergies in Schools*, available at:

   www.isbe.net/nutrition/pdf/food_allergy_guidelines.pdf.
3. Complies with State and federal law and is in alignment with Board policies.

LEGAL REF.: 105 ILCS 5/2-3.149 and 5/10-22.39.
Guidelines for Managing Life-Threatening Food Allergies in Schools (Guidelines), jointly published by the State Board of Education and Ill. Dept. of Public Health.

CROSS REF.: 4:110 (Transportation), 4:120 (Food Services), 4:170 (Safety), 5:100 (Staff Development Program), 6:120 (Education of Children with Disabilities), 6:240 (Field Trips), 7:250 (Student Support Services), 7:270 (Administering Medicines to Students), 8:100, (Relations with Other Organizations and Agencies)

ADOPTED: January 5, 2011

NewEmpOreint/PolicyLet/7285
8/11

Students 7:190

Student Discipline

Prohibited Student Conduct

The school administration is authorized to discipline students for gross disobedience or misconduct, including but not limited to:

1. Using, possessing, distributing, purchasing, or selling tobacco materials.
2. Using, possessing, distributing, purchasing, or selling alcoholic beverages. Students who are under the influence of an alcoholic beverage are not permitted to attend school or school functions and are treated as though they had alcohol in their possession.
3. Using, possessing, distributing, purchasing, or selling:
   a. Any illegal drug, controlled substance, or cannabis (including marijuana and hashish).
   b. Any anabolic steroid unless being administered in accordance with a physician's or licensed practitioner's prescription.
   c. Any performance-enhancing substance on the Illinois High School Association's most current banned substance list unless administered in accordance with a physician's or licensed practitioner's prescription.
   d. Any prescription drug when not prescribed for the student by a physician or licensed practitioner, or when used in a manner inconsistent with the prescription or prescribing physician's or licensed practitioner's instructions.
   e. Any inhalant, regardless of whether it contains an illegal drug or controlled substance: (a) that a student believes is, or represents to be capable of, causing intoxication, hallucination, excitement, or dulling of the brain or nervous system; or (b) about which the student engaged in behavior that would lead a reasonable person to believe that the student intended the inhalant to cause intoxication, hallucination, excitement, or dulling of the brain or nervous system. The prohibition in this section does not apply to a student's use of asthma or other legally prescribed inhalant medications.
   f. "Look-alike" or counterfeit drugs, including a substance not containing an illegal drug or controlled substance, but one: (a) that a student believes to be, or represents to be, an illegal drug or controlled substance; or (b) about which a student engaged in behavior that would lead a reasonable person to believe that the student expressly or impliedly represented to be an illegal drug or controlled substance.
   g. Drug paraphernalia, including devices that are or can be used to: (a) ingest, inhale, or inject cannabis or controlled substances into the body; and (b) grow, process, store, or conceal cannabis or controlled substances.

   Students who are under the influence of any prohibited substance are not permitted to attend school or school functions and are treated as though they had the prohibited substance, as applicable, in their possession.
4. Using, possessing, controlling, or transferring a "weapon" as that term is defined in the *Weapons* section of this policy, or violating the *Weapons* section of this policy.

5. Using or possessing an electronic paging device. Using a cellular telephone, video recording device, personal digital assistant (PDA), or other electronic device in any manner that disrupts the educational environment or violates the rights of others, including using the device to take photographs in locker rooms or bathrooms, cheat, or otherwise violate student conduct rules. Prohibited conduct specifically includes, without limitation, creating, sending, sharing, viewing, receiving, or possessing an indecent visual depiction of oneself or another person through the use of a computer, electronic communication device, or cellular phone. Unless otherwise banned under this policy or by the Building Principal, all electronic devices must be kept powered-off and out-of-sight during the regular school day unless: (a) the supervising teacher grants permission; (b) use of the device is provided in a student's individualized education program (IEP); or (c) it is needed in an emergency that threatens the safety of students, staff, or other individuals.
6. Using or possessing a laser pointer unless under a staff member's direct supervision and in the context of instruction.
7. Disobeying rules of student conduct or directives from staff members or school officials. Examples of disobeying staff directives include refusing a District staff member's request to stop, present school identification, or submit to a search.
8. Engaging in academic dishonesty, including cheating, intentionally plagiarizing, wrongfully giving or receiving help during an academic examination, and wrongfully obtaining test copies or scores.
9. Engaging in hazing or any kind of bullying or aggressive behavior that does physical or psychological harm to a staff person or another student, or urging other students to engage in such conduct. Prohibited conduct specifically includes, without limitation, any use of violence, intimidation, force, noise, coercion, threats, stalking, harassment, sexual harassment, public humiliation, theft or destruction of property, retaliation, hazing, bullying, bullying using a school computer or a school computer network, or other comparable conduct.
10. Causing or attempting to cause damage to, or stealing or attempting to steal, school property or another person's personal property.
11. Being absent without a recognized excuse; State law and Board policy regarding truancy control will be used with chronic and habitual truants.
12. Being involved with any public school fraternity, sorority, or secret society, by: (a) being a member; (b) promising to join; (c) pledging to become a member; or (d) soliciting any other person to join, promise to join, or be pledged to become a member.
13. Being involved in gangs or gang-related activities, including displaying gang symbols or paraphernalia.
14. Violating any criminal law, including but not limited to, assault, battery, arson, theft, gambling, eavesdropping, and hazing.
15. Engaging in any activity, on or off campus, that interferes with, disrupts, or adversely affects the school environment, school operations, or an educational function, including but not limited to, conduct that may reasonably be considered to: (a) be a threat or an attempted intimidation of a staff member; or (b) endanger the health or safety of students, staff, or school property.

For purposes of this policy, the term "possession" includes having control, custody, or care, currently or in the past, of an object or substance, including situations in which the item is: (a) on the student's person; (b) contained in another item belonging to, or under the control of, the student, such as in the student's clothing, backpack, or automobile; (c) in a school's student locker, desk, or other school property; or (d) at any location on school property or at a school-sponsored event.

Efforts, including the use of early intervention and progressive discipline, shall be made to deter students, while at school or a school-related event, from engaging in aggressive behavior that may reasonably produce physical or psychological harm to someone else. The Superintendent or designee shall ensure that the parent/guardian of a student who engages in aggressive behavior is notified of the incident. The failure to provide such notification does not limit the Board's authority to impose discipline, including suspension or expulsion, for such behavior.

No disciplinary action shall be taken against any student that is based totally or in part on the refusal of the student's parent/guardian to administer or consent to the administration of psychotropic or psychostimulant medication to the student.

The grounds for disciplinary action, including those described more thoroughly later in this policy, apply whenever the student's conduct is reasonably related to school or school activities, including but not limited to:

1. On, or within sight of, school grounds before, during, or after school hours or at any time;
2. Off school grounds at a school-sponsored activity or event, or any activity or event that bears a reasonable relationship to school;
3. Traveling to or from school or a school activity, function, or event; or
4. Anywhere, if the conduct interferes with, disrupts, or adversely affects the school environment, school operations, or an educational function, including but not limited to, conduct that may reasonably be considered to: (a) be a threat or an attempted intimidation of a staff member; or (b) endanger the health or safety of students, staff, or school property.

Disciplinary Measures

Disciplinary measures may include:

1. Disciplinary conference.
2. Withholding of privileges.
3. Seizure of contraband.
4. Suspension from school and all school activities for up to 10 days, provided that appropriate procedures are followed. A suspended student is prohibited from being on school grounds.
5. Suspension of bus riding privileges, provided that appropriate procedures are followed.
6. Expulsion from school and all school-sponsored activities and events for a definite time period not to exceed 2 calendar years, provided that the appropriate procedures are followed. An expelled student is prohibited from being on school grounds.
7. Notifying juvenile authorities or other law enforcement whenever the conduct involves illegal drugs (controlled substances), "look-alikes," alcohol, or weapons.
8. Notifying parents/guardians.
9. Temporary removal from the classroom.
10. In-school suspension for a period not to exceed 5 school days. The Building Principal or designee shall ensure that the student is properly supervised.
11. After-school study or Saturday study, provided the student's parent/guardian has been notified. If transportation arrangements cannot be agreed upon, an alternative disciplinary measure must be used. The student must be supervised by the detaining teacher or the Building Principal or designee.
12. Community service with local public and nonprofit agencies that enhances community efforts to meet human, educational, environmental, or public safety needs. NSSEO will not provide transportation. School administration shall use this option only as an alternative to another disciplinary measure giving the student and/or parent/guardian the choice.

A student who is subject to suspension or expulsion may be eligible for transfer to an alternative school program.

Corporal punishment is prohibited. Corporal punishment is defined as slapping, paddling, or prolonged maintenance of students in physically painful positions, or intentional infliction of bodily harm. Corporal punishment does not include reasonable force as needed to maintain safety for students, staff, or other persons, or for the purpose of self-defense or defense of property.

Weapons

A student who is determined to have brought one of the following objects to school, any school-sponsored activity or event, or any activity or event that bears a reasonable relationship to school shall be expelled for a period of at least one calendar year but not more than 2 calendar years:

1. A firearm, meaning any gun, rifle, shotgun, or weapon as defined by Section 921 of Title 18 of the United States Code (18 U.S.C. § 921), firearm as defined in Section 1.1 of the Firearm Owners Identification Card Act (430 ILCS 65/), or firearm as defined in Section 24-1 of the Criminal Code of 1961 (720 ILCS 5/24-1).
2. A knife, brass knuckles, or other knuckle weapon regardless of its composition, a billy club, or any other object if used or attempted to be used to cause bodily harm, including "look alikes" of any firearm as defined above.

The expulsion requirement under either paragraph 1 or 2 above may be modified by the Superintendent, and the Superintendent's determination may be modified by the Board on a case-by-case basis.

Required Notices

A school staff member shall immediately notify the office of the Building Principal in the event that he or she: (1) observes any person in possession of a firearm on or around school grounds; however, such action may be delayed if immediate notice would endanger students under his or her supervision, (2) observes or has reason to suspect that any person on school grounds is or was involved in a drug-related incident, or (3) observes a battery committed against any staff member. Upon receiving such a report, the Building Principal or designee shall immediately notify the local law enforcement agency, State Police, and any involved student's parent/guardian. "School grounds" includes modes of transportation to school activities and any public way within 1000 feet of the school, as well as school property itself.

Delegation of Authority

Each teacher, and any other school personnel when students are under his or her charge, is authorized to impose any disciplinary measure, other than suspension, expulsion, corporal punishment or in-school suspension, that is appropriate and in accordance with the policies and rules on student discipline. Teachers, other certificated educational employees, and other persons providing a related service for or with respect to a student, may use reasonable force as needed to maintain safety for other students, school personnel, or other persons, or for the purpose of self-defense or defense of property. Teachers may temporarily remove students from a classroom for disruptive behavior.

The Superintendent, Building Principal, or Assistant Building Principal is authorized to impose the same disciplinary measures as teachers and may suspend students guilty of gross disobedience or misconduct from school (including all school functions) and from riding the school bus, up to 10 consecutive school days, provided the appropriate procedures are followed. The Board may suspend a student from riding the bus in excess of 10 school days for safety reasons.

LEGAL REF.: Gun-Free Schools Act, 20 U.S.C. §7151 et seq.
Pro-Children Act of 1994, 20 U.S.C. §6081.
105 ILCS 5/10-20.5b, 5/10-20.14, 5/10-20.28, 5/10-20.36, 5/10-21.7, 5/10-21.10, 5/10-22.6, 5/10-27.1A, 5/10-27.1B, 5/24-24, 5/26-12, 5/27-23.7, and 5/31-3.
23 Ill.Admin.Code §1.280.

CROSS REF.: 2:240 (Board Policy Development), 5:230 (Maintaining Student Discipline), 6:110 (Programs for Students At Risk of Academic Failure and/or Dropping Out of School and Graduation Incentives Program), 7:70 (Attendance and Truancy), 7:130 (Student Rights and Responsibilities), 7:140 (Search and Seizure), 7:150 (Agency and Police Interviews), 7:160 (Student Appearance), 7:170 (Vandalism), 7:180 (Preventing Bullying, Intimidation, and Harassment), 7:200 (Suspension Procedures), 7:210 (Expulsion Procedures), 7:220 (Bus Conduct), 7:230 (Misconduct by Students with Disabilities), 7:240 (Conduct Code for Participants in Extracurricular Activities), 7:270 (Administering Medicines to Students), 7:310 (Restrictions on Publications), 8:30 (Visitors to and Conduct on School Property)

ADOPTED: January 5, 2011

NSSEO

BEHAVIOR MANAGEMENT

PROCEDURE FOR STUDENTS IN

CRISIS

Revised Final/Draft July 2009

TABLE OF CONTENTS

ACKNOWLEGEMENTS

The 1998 Revisions Committee wishes to acknowledge the original 1992 committee members:

Nancy Bator-Smith

Dr. Ann Farrell

Michael Hertz

Michael Meyer

Dr. Alice Zemitzsch (Epstein)

For their wonderful contribution in the development of Behavior Management Procedures for NSSEO, most of which remain as guiding principles, if not direct content in our current effort.

Our appreciation is further extended to the following parent/parent representatives for their review and enthusiastic endorsement of these procedures:

Susan McKinney, House Parent, Little City

Diana Mielak, Surrogate Parent

John P. Sime, Parent

INTRODUCTION

These procedures were developed to define parameters for staff when interacting with acting out, out of control, and/or dangerous students, i.e., students in crisis. The procedures also define staff behavior when the use of physical restraint of students becomes necessary.

The Illinois School Code allows public school staff to use "reasonable force" when necessary to maintain safety for other students, school personnel or persons, or for the purpose of self defense, or the defense of property. NSSEO policy-Section JD, authorizes NSSEO staff members to "use restraining methods in controlling the student"; however, the teaching of "self discipline" rather than solely relying on the use of physical interventions, is emphasized.

Illinois Public Act 87-1103, the use of Behavioral Interventions for Students with Disabilities requires that public school staff rely on non-aversive or positive intervention to the maximum extent possible when attempting to teach and strengthen desirable behavior in students. Furthermore, if it is anticipated that school staff may likely use restrictive interventions (such as physical restraint), then a functional analysis/behavior management plan must be developed with the student's parents as part of the student's IEP. [1] Therefore, when dealing with acting out or potentially dangerous students, NSSEO staff shall utilize a hierarchical application of intervention. This principle requires the use of more intrusive (restrictive) interventions **ONLY** after less intrusive (nonrestrictive) ones have been attempted. In essence, these procedures permit physical restraint only as a last resort, after nonphysical interventions have been attempted **AND/OR** when there is imminent and serious danger to the student or others. If physical restraint is used, it shall be done in a safe, non-harmful, and therapeutic manner as much as possible.

In keeping with these principles, NSSEO adopts the CPI Model [2] as a major methodological approach which attempts to deescalate student behavior that is out of control, i.e., "in crisis" and/or presents a danger to self or others. Other methods which are consistent with the CPI model and can be used during the nonverbal and verbal levels of crisis will also be utilized by staff. Some of these methods are detailed in the appendices (B, C, D, E, F).

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[1] See Appendix F-NSSEO Behavior Intervention Procedure for Students with Disabilities.

[2] National Crisis Prevention Institute, Inc. (CPI), Brookfield, WI 1987

BEHAVIOR MANAGEMENT PROCEDURES FOR STUDENTS IN CRISIS

(Note: This Section is not intended as a substitute for CPI certification)

The first step in defusing a potentially explosive situation is to recognize the warning sign that would enable the staff member to deescalate the student before he/she becomes assaultive. A variety of nonverbal and verbal behavior management techniques that can interrupt the escalation must be attempted first.

- Staff shall identify the level of crisis a student is experiencing and respond with an appropriate intervention (staff Attitude).[3]
- At the nonverbal level of crisis, staff will attempt to prevent the crisis from developing further by attempting to alleviate student anxiety through a variety of supportive and empathic methods.[4]
- At the verbal level of crisis, staff will attempt to diffuse the crisis through a variety of techniques aimed at directing or redirecting the verbal assault. These techniques shall attempt to set verbal limits for the student.[5]
- At the physical acting out level or crisis, staff shall employ non-violent, therapeutic, physical crisis intervention techniques.[6] These techniques are employed as a last resort when other less restrictive methods have failed and/or when student behavior is a direct threat to safety of staff, other students, or self. Additionally, these techniques are only employed long enough in order to restore the situation to one of safety.

  Note: the CPI restraint is designed as a standing control. It is assumed that teams utilizing the CPI non violent physical crisis intervention technique will practice frequently in order to maintain efficiency in its use. If restraint is necessary, control is always attempted from a standing position. However, on occasion, a student may unintentionally progress to the floor. If this situation occurs, the team has three alternatives:

  1) The team may attempt to lift the student in order to regain a standing restraint posture.
  2) The team may release the student. Many times safety is no longer an issue and therefore, other less restrictive intervention can be employed. On occasion, release of a student may allow the team to readjust and attempt a standing restraint again.

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[3] CPI, 1987

[4] See Appendix A, B, C, D, F

[5] See Appendix A, B, C, D, E, F

[6] CPI 1987

3) The team may continue the hold on the floor if the three control dynamics i.e., reduction of arm and upper body strength/reduction or legs and lower body strength/reduction of mobility are adhered to. [7]

The choice of these alternatives shall be determined by the team leader.

- At the conclusion of a crisis episode, staff will engage in a teaching-learning intervention in order to re-teach student behaviors and reestablish communication with the student.[8]
- Any adult alone with a student who has become physically aggressive must immediately call for support staff and maintain a safe distance for the other students and him or her self.
- Use of non-violent physical crisis intervention with students who have any medical conditions, (i.e., asthma, epilepsy, heart conditions, psychotropic meds, ext.), must be reviewed and approved by the certified school nurse before any physical intervention is used, and at the same time , the student IEP/Functional Analysis Behavior Management Plan is developed and/or revised. It is the responsibility of staff members to familiarize themselves with the information contained in the student's temporary and health records.
- If an intervention is used that involves an issue or potential issue of health and safety, then an incident report must be completed by staff. (See Appendix G.) The incident report shall be written in a manner that describes the essential facts of the situation as well as the rationale for the intervention utilized by staff.

[7] Consultations with CPI-3/2/98: 3/6/98-by Greg Best. NSSEO

[8] CPI, 1987

APPENDIX A

National Crisis Prevention Institute, Inc.

The various techniques, interventions and methodologies employed in CPI model are acquired through successful staff completion of twelve hour certified CPI (Crisis Prevention Institute) training program conducted by on-site certified instructors.

Copyright laws and CPI regulations prohibit dissemination of material outside the confines of a certified initial or refresher training program.

APPENDIX B

General Principles of Behavior Management

The primary emphasis in all educational/vocational/community settings where instruction occurs is to design the learning environment to prevent the need for physical intervention.

- Be clear about the nature of acceptable behavior.
- Be precise about limits set.
- Make sure the student understands the terms used when setting rules/standards.
- Make sure that consequences are given when a rule is broken, with an opportunity to "recoup" some of the cost when compliance is achieved.
- Be consistent each time a consequence is used.
- Communicate positive feelings.
- Don't inflict consequences when you are angry.
- Separate the behavior from the student when pursuing consequences. Attempt to identify the goal of the behavior.
- Give verbal and nonverbal directions.
- Give the student choices which are reasonable.
- Provide positive feedback as the student begins to comply.

The behavior intervention used should also be though of as a learning experience. It must be remembered that disruptive behavior reflects the student's past learning history; that new behavior must be taught, and appropriate behavior can be learned.

APPENDIX C

NON-PHYSICAL NTERVENTIONS

Conflict in the Classroom, Long, Morse, and Newman

Belmont, CA, Wadsworth (3rd Edition), pp. 308-316, 1996.

The following interventions are abridged from Nicholas J. Long and Ruth G. Newman, "A Differential Approach to the Management of Surface Behavior of Children in School." These techniques are designed to help a teacher maintain the surface behavior of children during difficult periods. They are only stop-gap methods and do not substitute for a well designed program or replace the teacher's knowledge of individual and group psychology.

The twelve influence techniques to be discussed are planned ignoring, signal interference, proximity control, interest boosting, tension decontamination through humor, hurdle help, restricting the classroom program, support from routine, direct appeal, removal of seductive objects, antiseptic bouncing, and physical restraint.

1. **Planned Ignoring.** Much of children's behavior carries its own limited power and will soon exhaust itself if it is not replenished, especially if the behavior is designed to "get the teacher's goat." Assuming that the behavior will not spread to others, it might be wise for the teacher to ignore the behavior and not fed into the child's need for secondary gratification. In the following example, the teacher is aware of the underlying meaning of the boy's behavior.

   One technique that I find successful is to ignore disruptive behavior. It works most successfully with Frank. When he starts dropping his pencils or tapping his feet. I know that it is a signal that I had better get over there in a few minutes and help him. I have found, however, that if I confront him with this behavior, he usually argues with me and causes additional problems.

   In this example, the teacher responds to the motivation of the behavior and not of the manifestations of the behavior.

2. **Signal Interference.** Teachers have developed a variety of signals that communicate to the child a feeling of disapproval and control. These nonverbal

techniques include such things as eye contact, hand gestures, tapping or snapping fingers, coughing or clearing one's throat, facial frowns, and body postures. Such nonverbal techniques seem to be most effective at the beginning stages of misbehavior.

When a student is acting up in a mild way, I have found that a glance in his direction will usually stop the behavior temporarily. Usually I do not have to look at a child for long time before he is aware that I am looking at him. I have also found that this technique is most helpful with those students who like me. Another signal that I have used is to stand up from my desk when there is a lot of whispering.

3. **Proximity Control.** Every teacher knows how effective it is to stand near a child who is having some difficulty. Just as a crying infant will stop crying when he is picked up by his mother, although the actual source of discomfort still exists the early elementary child usually can control his impulses if he is close to the teacher. The teacher operates as a source of protection, strength, and identification. As one of the teachers explains:

One technique I have found helpful is to walk among the children. As I walk down the rows, I help the children having trouble with their work, or I give the bored ones something else to do. My closeness and help show that I am interested and concerned. It creates a better atmosphere and rapport and diminishes problems. I have found it very helpful and more effective than just standing behind the desk and telling them what to do. When I have a child who needs more than the usual help, I usually put his desk close to mine so that we are both aware of each other.

There are some children who not only need to have an adult close by but who also need the adult to touch them before they are able to control their impulses. This is done by having the teacher put his hand gently on the child's shoulder. This action should not be confused with the teacher who leaves five red marks after he has made physical contact with the child.

The advantage of these three techniques-planned ignoring, sign interference, and proximity control, are that they do not embarrass or even identify the child in the group. The teacher may use all three of these techniques while maintaining his/her classroom program.

4. **<u>Interest Boosting.</u>** If a child interest is waning and he is showing signs of restlessness, it is sometimes helpful for the teacher to show some genuine interest in the child's classroom assignment, asking whether problem 10 was very hard for him or mentioning his personal interest in athletics, cars, etc. Tapping a child's area of interest may help him mobilize his forces and view the teacher as person whom he wants to please. One teacher described an experience with a child with whom he used this technique as follows:

   Craig was crazy about dinosaurs. He read about them; he drew pictures of them; and he even had a plastic collection of them. As you can guess, Craig was a problem. He did not bother the boys or girls or defy me, but he would spend his class time either daydreaming or else drawing pictures of dinosaurs. I talked to him many times about this and he promised to stop; but, the following day, he was back at his drawings. I decided that if I could not fight him, perhaps I could join him in his interest. That night I spent the evening reading the Encyclopedia Britannica. The next day I told Craig that I was very interest in dinosaurs too and even had a course in college that studied them. Craig was somewhat skeptical of my comment, but after I mentioned some vital statistics about dinosaurs he was impressed that I was an expert in the field. Together we studied dinosaurs but structured the work so that it would only take place after he had completed his regular assignments.

5. **<u>Tension Decontamination through Humor.</u>** There is nothing new about this technique. Everyone is aware of how a humorous comment is able to penetrate a tense and anxiety-producing situation. It clears the air and makes everyone feel more comfortable. The example below shows how one teacher used this technique advantage.

   I walked into my room after lunch period to find several pictures on the chalk board with "teacher" written under each one. I went to the board and picked up a piece of chalk, first looking at the class. You could have heard a pin drop. Then, I walked over to one of the picture and said that this one looked the most like me but needed some more hair, which I added. Then, I went to the next one and said that they had forgotten my glasses, so I added them. One the next one, I suggested adding a big nose, and on the last one, a longer neck. By this time, the class was almost in hysterics. Then, seeing that the children were having such a good time, and that I could not get them settled easily, I passed out drawing

paper and suggested that they draw a picture of the funniest person they could make. It is amazing how original these pictures were.

This example illustrated the phenomenon of group testing. The pictures were put on the board to test the vulnerability of the teacher. Some teachers would have reacted with sarcasm. They might have said that his was infantile behavior and not becoming a fifth grade class. Other teachers might have given the class extra work or administered a group punishment, such as denial of recess or free time. However, this teacher demonstrated that she was secure, that a drawing could not cause her to regress or to become counter aggressive and that she could be counted on during stressful periods.

Here is another excellent example of tension decontamination:

As soon as I entered the room, two students who had remained in the room during the playground period informed me that Stella and Mary had a fight in the girls' restroom and were at present being seen by the principal. Since both of these girls are good pupils and are well like by the class, I imagined that they and the girls were wondering what I would do when the two girls returned to the room. Fifteen or twenty minutes elapsed before the girls returned. They entered and took their seats, and the room became very quiet. I closed my book, looked at one of the girls and said in a rasping voice of a fight announcer, "And, in this corner, we have Stella, weighing 78 pounds." Everyone laughed. The tension vanished and we proceeded with our work.

Once again, humor was used to communicate to the class that everything was alright; that there was no need to worry about it, and that the children could relax and return to their lessons.

6. **Hurdle Lessons.** Disturbing behavior is not always the result of some inner problem. Sometimes the child is frustrated by the immediate classroom assignment. He does not understand the teacher's directions or is blocked by the second or third step in a complicated long division problem. Instead of asking for help and exposing himself to the teacher's wrath for not paying attention or for exhibiting his educational inadequacies, the child is likely to establish contact with his neighbors, find some interesting trinket in his pocket, or draw on his desk. In other words, he is likely to translate his frustrations into

motor behavior. The solution is to provide the child with help he needs before the situation gets to this stage, as was done in the following example:

Sonya was very stubborn and usually persisted in not doing her work. After making an assignment, I would give the students some time to work on it in class. I would walk around the room and casually stop at Sonya's desk. Noting that she had not started, I would ask her some of her ideas and would suggest that she write those thoughts on paper. She could do the work and would do it if I explained it to her and personally got her interested in it. If I let her alone, she would usually sit and begin filing her nails or looking at the boy next to her who would become quite flushed. While this technique meant more work for me, it finally paid off because as soon as she began working, she worked without assistance and began making passing grades.

7. **Restructuring the Classroom Program.** How much can a teacher deviate from his scheduled program and still feel he is meeting his "teaching responsibilities?" Another way of asking this question is, "Does the teacher control the program, or does the program control the teacher?" For example, some teachers feel compelled to follow their class schedule with no "ifs", "ands", or "buts." Otherwise, they feel they cannot hope to complete the assigned course of study. Besides, they feel children must learn not to be affected by every passing emotion. They must learn how to concentrate even under undesirable circumstances. Other teachers voice a difference position. They feel that the complexity of life and the many extenuating forces make it impossible to follow a standardized course. The task is not so much to teach children as to provide the conditions under which learning can take place. Perhaps these are straw arguments, and the question that needs to be raised is, "Does restructuring a program ever facilitate learning? If so, under what conditions?" This takes the task out of realm of "either-or" arguments and places it in the teacher's ability to predict the tension level of the class in terms of feelings of irritability, boredom, or excitement. If the tension is decreasing, he may decide not to redesign his program. However, if he decides that the tension needs to be drained off, i.e., verbalized or channeled before the class can involve itself in the next assignment, he may change his program immediately.

   Two interesting examples are presented below:

Shortly before a grade school basketball tournament, I was forced to cancel basketball practice for the evening. This met with much disapproval from the team members. The lesson for civics that day concerned labor strikes. As I walked into the classroom, I detected the basketball boys were signaling for everyone to remain silent. It looked as though they were going to have fine cooperation from the rest of the class. Seeming to be completely unaware of their intentions, I cancelled our discussion period and proceeded to assign them the written work. I explained at the end of the chapter this work was necessary before we could discuss the chapter adequately. The period was spent in constructive work and avoided a head-on clash. Later, I talked to the boys and explained why I had to cancel the practice.

The next example of restructuring illustrates how a teacher created an atmosphere of comfort and relaxation.

The children were just returning to the room after the recess period. Most of them we flushed and hot from exercise and were a little irritable. They were complaining of the heat in the room, and many of them asked permission to get a drink of water as soon as the final recess bell rang. I felt it would be useless to begin our history study as scheduled, so I told all of the children to lay their heads upon their desks. I asked them to be very silent for one minute and to think of the coolest thing they could imagine during that time. Each child then told the class what he had been thinking. The whole procedure lasted roughly ten minutes, and I felt that it was time well spent. The history period afterward went smoothly; the atmosphere within the room relaxed, and the children were receptive.

8. **Support from Routine.** We all need structure. Some children need much more than other children before they can feel comfortable and secure. Without these guide posts for behavior, some children become anxious and hyperactive. This is especially true during unstructured time when children are moved by every wind and breeze of classroom behavior. Most beginning junior high school children find themselves in this state during the first few weeks. One boy summarized his feelings by saying, “It’s like one great big surprise. Each hour you go to another teacher and you don’t know what’s going to happen until it’s too late.” To help these children, a daily schedule or program should be provided, as this may allay some of their feelings of anxiety. They can predict what is expected of them and prepare themselves for the next activity. As one teacher says:

Each morning I outline the activities for the day with one "leading question." I find that this is helpful to some of the children. When they come into class, they start thinking about the activities we have planned instead of waiting for me to announce them. This saves time and eliminates the majority of random behavior.

9. **Direct appeal to Value Areas.** One of the most frequent mistakes of an untrained teacher is that he feels he must intervene severely and drastically in order to demonstrate that he has control of the situation. We know that this is not desirable. Another alternative is to appeal to certain values that the students have internalized. The conflict is that some children have not internalized the same values that the teacher has internalized. For example, a teacher cannot appeal to the child's sense of fairness if the child feels he has been "gypped" out of something he has a right to possess.

   A partial list of some of the values that most teachers can appeal to includes:

   a) An appeal to the relationship of the teacher with the child, i.e., "You are treating me as if I did something bad to you! Do you think I have been unfair to you?"
   b) An appeal to reality consequences, i.e., "If you continue to talk, we will not have time to plan our party." "If you continue with this behavior, these are the things that will probably happen." In other words, the teacher tries to underline cause and effect behavior.
   c) An appeal to the child's group code and awareness of peer reaction, i.e., "What do you think the other boys and girls will think of that idea?" or "If you continue to spoil their fun, you can't expect the other boys and girls to like you."
   d) An appeal to the teacher's power of authority. Tell the children that as a teacher, you cannot allow this behavior to continue and still want to take care of them. The trick is to learn how to say "no" without becoming angry, or how to say "yes" without feeling guilty.

10. **Removing Seductive Objects.** Teachers have learned that they cannot compete against such seductive items as a baseball in a group of boys or a picture of the latest crooner in group of pre-adolescent girls. Either the objects have to be

removed or teachers have to accept the disorganized state of the group. It is not entirely the children's fault. Certain objects have a magnetic appeal and elicit a particular kind of behavior from children. For example, if a child has a flashlight it says "turn me on;" if he has a ball it says "throw me;" if he has a magnifying glass, it says "reflect the sunlight;" if he has a whistle, it says "toot me;" if he has a pea shooter, it says "shoot me," and so on. These objects feed into the child's impulse system, making it harder for children to control their behavior. One of the most exasperating experiences in a teacher's lifetime is to set up a science corner only to have it fingered to death in the first five minutes of bell time.

11. **<u>Antiseptic Bouncing.</u> (Also see Appendix E-Time Out Interventions)** When a child's behavior has reached a point where the teacher questions whether the child will respond to verbal controls, it is best to ask the child to leave the room for a few minutes-perhaps to get a drink, wash up, or deliver a message. This was done in the following situation:

    One morning during arithmetic study period, I became aware of giggling in the back of the room. I looked up to see that Joyce had evidently thought of something hilariously funny. I tried signal interference, and, though she tried to stop, she succeeded only in choking and coughing. By now, most of the children around her were aware of the circumstances and were smothering laughter too. I hurriedly wrote a note to the secretary of the principal's office explaining that Joyce "had the giggles" and asked that she keep her waiting for a reply until she seemed settled down. I asked Joyce if she would mind delivering the message and waiting for an answer. I think she was grateful for the chance to leave the room. When she returned, she appeared to have everything controlled, as had the class and things proceeded normally.

    In antiseptic bouncing, there is no intent of punishing the child, but simply to protect and help him and/or the group to get over their feelings of anger, disappointment, uncontrollable laughter, hiccups, etc. Unfortunately, many schools do not have a place that would not connote punishment to which the classroom teacher can send a child. To send him to the principle where he sits on the mourner's bench is not very helpful and defeats the purpose of non-punitive management. However, with staff planning, it is amazing what alternative can be found.

APPENDIX D

SAMPLE INTERVENTIONS FOR SPECIFIC BEHAVIORS

When developing a student's classroom Behavior Management Plan, several factors should be considered in selecting the appropriate intervention, such as chronicity, severity, intent, and personal incidents surrounding the individual student at any particular time. Keeping this in mind, the following provides a sampling of interventions that can be considered when responding to specific behaviors:

Minor Aggression	**Sample Interventions (*)**
1. Name calling inappropriate gestures, teasing, provoking, non-directed throwing of small objects without contact.	Individual Behavior Management Plan. • Planned ignoring • Verbal warning • Discussion • Repeat verbal direction • Give student a choice to cooperate • Life space interview • Redirection • Cueing • Time out • Proximity control • Environmental change • Prompts • Earn positives • Signal interference • Interest boosting • Direct appeal • Model/practice appropriate behavior • Reinforcement of appropriate behavior of others
2. Verbal threatening, invading space without contact, directed throwing of object without contact (pencils, pens, spitballs, food), possession of a potentially dangerous object or weapon	Previously mentioned interventions could also be implemented at this stage: • Repeat verbal direction • Return to quiet area in classroom • Change activity • Move other students out

- Room calm down
- Reinforcement
- Involve additional personnel to assist in problem solving
- Exclusion time out.

3. Minor physical contact without bodily harm such as those instances of shoving, pushing, swatting, hitting, spitting, or kicking in which no one is injured.

Previously mentioned interventions could be implemented at this stage:

- Discussion with student
- Return to quiet area in classroom
- Give student(s) a choice to cooperate
- Separate the students with verbal directions
- Signal interference
- Proximity control
- Discussion
- Group reinforcer
- Involve additional personnel to assist in problem solving
- Room calm down

4. Directed or non-directed throwing of small objects with physical contact in which no one is injured.

- Separation to carrel, or quiet area, or hall for discussion, intervention, problem solving meeting.
- Supportive stance
- Signal interference
- Room calm down and practice appropriate behavior
- Group reinforcer
- Involve additional personnel to assist in problem solving
- Exclusion time out

5. Minor property damage without injury, slamming doors, shoving desks or carrels, throwing books.

Previously mentioned interventions could also be implemented at this stage:

- Separation to carrel, quiet area or hall for discussion, intervention, problem solving meeting

- Room calm down and practice appropriate behavior
- Group reinforcer
- Exclusion time out
- Community service

Major Aggression

1. Major verbal threatening with potential of severe bodily harm and/or serious damage. Examples: Threatening by a student who has the potential to follow through the threat.

Depending on the degree of aggressive threatening, the following steps should be taken:

- Move to quiet area
- Problem solving meeting
- Individual Behavior Management Plan review
- Placement in an alternative learning situation
- Chronicity of behavior may warrant polices contact.

2. Aggression with physical contact that has caused bodily harm or extensive damage. Threatening by a student who is holding a potentially dangerous object.

Depending on the degree and intent of behavior, the following steps should be taken:

- Parent contact
- Cool off time
- Problem solving meeting
- If warranted, police contact
- Nonviolent physical crisis intervention
- Placement in an alternative learning situation

3. Possession of a weapon (i.e., gun, knife, martial arts paraphernalia)- Intent and size weapon, other than a gun, determines intervention.

Possession of a weapon, other than a gun, warrants the confiscation of said object(s) and parent and/or police may be contacted:

- Possession of a gun warrants confiscation police and parent contact.
- Follow **IDEA** requirements

(*)These interventions are not meant to be a complete listing of possible staff actions.

APPENDIX E

TIME OUT INTERVENTIONS

The use of a time of procedure often eliminates the need for a more intrusive intervention.

There are three different levels of time out:

Nonexclusionary/Instructional is a procedure in which the student is removed form the classroom activity to another area of the room where he/she can observe but not participate for a specified period of time.

Exclusionary time out is a procedure in which the student is removed from the reinforcing setting for a specified period of time. Here, the student is totally removed from the classroom activities, but is not removed to total isolation, e.g., to the hallway.

*Seclusionary time out is a procedure in which the student is removed from the classroom setting and placed in an isolation area supervised by a staff member for a set period of time contingent on a specified behavior. This type of time out is to be supervised by an adult.

All time outs have reasonable time limits based on the individual student's IEP/Behavior Management Plan.

(*) Seclusionary time out should be implemented if all other management techniques have failed to resolve the problem. There are three indicators for seclusionary time out. These are:

- To prevent imminent harm to the student and/or others.
- To prevent serious disruption in the classroom routine and/or to the learning environment of the program.
- To implement the student's specified Behavior Management Plan.

It should be noted that seclusionary time out is more restrictive than a normal time out within the classroom and should ***only*** be used with those students who are a threat to themselves or others and who need a less stimulating, safe area in order to regain control.

APPENDIX F

NSSEO BEHAVIOR INTERVENTION

PROCEDURES FOR STUDNETS

WITH DISABILITIES

Building a promising future for students

NSSEO

Northwest Suburban Special Education Organization

Payroll Information

EVERYTHING YOU EVER WANTED TO KNOW ABOUT YOUR NSSEO PAYCHECK

Northwest Suburban Special Education Organization
799 West Kensington Rood • Mount Prospect, Illinois 60056-1111

EMPLOYEE NO.	SOCIAL SECURITY	CHECK DATE

REGULAR	OVERTIME	RATE	EARNINGS

LOOK FOR MESSAGES IN THIS AREA CONCERNING CHANGES OR UPCOMING EVENTS

GROSS	TRS	IMRF	ANNUITY	THIS	TAXABLE PAY

FED. W/T	ST. W/T	F.I.C.A.	MEDICARE	INSURANCE	DENTAL	CREDIT UN.	DUES	MISC.	KIDS	NET PAY

YEAR TO DATE TOTALS	GROSS	TRS/IMRF	ANNUITY	TAXABLE	FED. W/T	ST. W/T.	F.I.C.A.	MEDICARE	INSURANCE

EMPLOYEE NO. — Number assigned by payroll/personnel dependent upon assignment and job classification.

SOCIAL SECURITY NO. — Only the last four digits of your Social Security Number is listed.

CHECK DATE — Payroll date

REGULAR — Statement that reflects if payment is based on a hourly/daily rate and the number of hours/days. Used for extra duty compensation or substitute pay.

OVERTIME — Paid to staff who qualify for overtime. This time is beyond the 40 hour work week.

RATE — Identifies how the employee is paid. "Salary" means paid according to contract; "Absence" means a payroll deduct applied. If an employee is paid an hourly rate or daily rate; the dollar amount is shown.

EARNINGS — The total in this column will equal your gross pay.

GROSS — Your gross salary for this pay period. 

TRS — The mandatory amount deducted that is paid to the Teachers' Retirement System at the rate of 9.4% of gross salary.

IMRF — The mandatory amount deducted that is paid to the Illinois Municipal Retirement Fund at the rate of 4.5% of gross salary for all IMRF covered employees.

ANNUITY — Amount deducted per employee's request for 403b plans. Please be advised there are certain restrictions and caps that must be followed to meet IRS regulations. You should check with your 403b representative to assure the you are deducting the appropriate amount.

THIS — Mandatory amount deducted for all TRS employees that is paid to the Teachers' Health Insurance Security Fund at the rate of .88% of gross salary.

TAXABLE PAY	Taxable pay = Gross pay minus TRS, IMRF, THIS, annuity and tax deferred family medical coverage. This is the amount upon which your Federal and State taxes are calculated.
FED. W/T 	Federal taxes withheld based on taxable pay and your most current W-4 tax form and calculated at IRS determined rates. These rates are subject to change.
STATE W/T	State taxes withheld based on taxable pay and your most current Illinois W-4 form at a rate of 3%. This rate has remained stable.
F.I.C.A.	Federal Insurance Contributions Act. This is Social Security tax for all non-certified employees at 6.2 % of your gross pay.
MEDICARE	Mandatory deduction of 1.45% on the gross pay amount of all non-certified staff . This amount is also deducted for all certified staff hired after 1986.
INSURANCE	Individual and family medical insurance coverage deduction which is tax deductible at the employees' request.
DENTAL	Family dental insurance coverage deduction.
CREDIT UNION	Two credit unions, AAEC and Metro, are currently available to NSSEO employees. Deductions are based on employee requests.
DUES	Deduction for the NSSEA and NSSEA ESP associations' dues per union contract. This deduction is only taken during the October-May time period.
MISC.	Miscellaneous deductions such as IMRF voluntary life insurance, wage garnishments, additional Reliance life insurance coverage and any flat amount deductions (Change for Kids).
KIDS	The Change for Kids donation not to exceed .99 cents if requested. 
NET PAY	This amount is your actual pay. If you have direct deposit, this is the amount that will be deposited in your account.
YEAR TO DATE TOTALS	These are your annual **calendar year totals**, **not school year totals**. Some of these totals, specifically your Federal and State , FICA and Medicare taxes will be reflected on your year-end W-2 forms.

YOUR "SALARY" IS DIVIDED INTO EQUAL PAYMENTS BASED ON THE NUMBER OF PAYCHECKS YOU WILL RECEIVE. THE NUMBER OF PAYCHECKS IS CONTINGENT UPON THE DATE OF HIRE .

ANY QUESTIONS REGARDING YOUR PAYCHECK SHOULD BE DIRECTED TO CYD WALLOCH AT CENTRAL OFFICE, 847-463-8124.

NOTICE TO ELIGIBLE EMPLOYEES OF THE OPPORTUNITY TO MAKE ELECTIVE DEFERRALS TO THE NSSEO 403(b) PLAN

You have the right to make elective deferrals to the NSSEO 403(b) Plan. Contributing to a 403(b) plan helps to ensure that you will have funds to provide yourself with an income during retirement. A 403(b) plan allows you to contribute a portion of your compensation on a pre-tax basis in order to save for your retirement. Contributions are made to the plan by payroll deduction. If you are already contributing to the 403(b) Plan, you may want to increase your deduction.

What are the benefits of contributing to a 403(b) plan?

- The pre-tax elective deferrals that you make to the plan now are not taxed until you withdraw them. This means you are lowering your taxable income now, and will potentially lower the amount of income tax you will pay on those funds at the time of withdrawal when you may be in a lower tax bracket.
- Both your pre-tax elective deferrals and earnings grow tax-free until they are withdrawn.

What do I need to do in order to start making elective deferrals?

You will need to make an election regarding how much of your compensation you wish to defer to the 403(b) plan. You will also need to determine where you want to invest your contributions. The list of approved vendor(s) and their contact information can be located by visiting the NSSEO Website at www.nsseo.org, or the CPI Participant Website at www.cpicrs.com. This list can also be obtained by contacting Cyd at NSSEO, phone number (847) 463-8124, email cwalloch@nsseo.org, or the CPI Participant Service Center at (877) 488-4040 or email Participant.ServiceCenter@cpicrs.com. The financial advisor representing each vendor will provide you with the forms that will set up the contract or account with the vendor. Once you have completed the paperwork provided by the selected financial advisor please access the CPI Participant Website at https://www.cpicrs.com to complete the election process.

If you are unable to access the website or want additional information, please contact the CPI Participant Service Center at (877) 488-4040 or email Participant.ServiceCenter@cpicrs.com or contact Cyd at (847) 463-8124 or email cwalloch@nsseo.org.

How much can I contribute to a 403(b) plan?

In 2010, you can make elective deferrals up to $16,500. As this amount is subject to cost of living increases as set by the government, this amount will increase over time. If you will be age 50 or older sometime during the 2010 calendar year, you are eligible to contribute an additional amount that is known as an "age 50 catch-up contribution". The limit on the age 50 catch-up contribution is $5,500 and can be contributed on top of the deferral limit of $16,500. Consequently, participants eligible to make the age 50 catch-up contributions can contribute up to $22,000 to the 403(b) Plan for the 2010 calendar year.

In addition to the age 50 catch-up, If you have completed at least 15 years of service with NSSEO you may be eligible to contribute up to $3,000 a year above the elective deferral limit until the amount of the cumulative annual additional contributions made using this special rule equals $15,000. If you have 15 years of service with your employer and want to utilize this additional 15 year of service catch-up contribution no action is required now, once you have exceeded $16,500 we will request additional information from you in order to determine the amount you are able to contribute to the 15 year of service catch-up. Participants who are eligible for both the age 50 catch-up rule and the 15 year of service catch-up contribution are required to use the 15 year of service catch-up contribution first.

For more information on enrolling in your 403(b) Plan, making changes to your current deferral or vendor elections, or any other questions or requests for information you may contact the CPI Participant Service Center at (877) 488-4040 from 7:00 a.m. to 7:00 p.m. Central time, Monday through Friday or e-mail Participant.ServiceCenter@cpicrs.com. You may also contact Cyd at NSSEO, phone number (847) 463.8124 from 8:00 a.m. to 4:30 p.m. Monday through Friday or email cwalloch@nsseo.org.

Building a promising future for students

NSSEO

Northwest Suburban Special Education Organization

Technology

Instruction

Access to Electronic Networks

Electronic networks, including the Internet, are a part of the District's instructional program and serve to promote educational excellence by facilitating resource sharing, innovation, and communication. The Superintendent shall develop an implementation plan for this policy and appoint system administrator(s).

The School District is not responsible for any information that may be lost or damaged, or become unavailable when using the network, or for any information that is retrieved or transmitted via the Internet. Furthermore, the District will not be responsible for any unauthorized charges or fees resulting from access to the Internet.

Curriculum

The use of the District's electronic networks shall: (1) be consistent with the curriculum adopted by the District as well as the varied instructional needs, learning styles, abilities, and developmental levels of the students, and (2) comply with the selection criteria for instructional materials and library resource center materials. Staff members may, consistent with the Superintendent's implementation plan, use the Internet throughout the curriculum.

The District's electronic network is part of the curriculum and is not a public forum for general use.

Acceptable Use

All use of the District's electronic networks must be: (1) in support of education and/or research, and be in furtherance of the goals stated herein, or (2) for a legitimate school business purpose. Use is a privilege, not a right. Students and staff members have no expectation of privacy in any material that is stored, transmitted, or received via the District's electronic networks or District computers. General rules for behavior and communications apply when using electronic networks. The District's *Authorization for Electronic Network Access* contains the appropriate uses, ethics, and protocol. Electronic communications and downloaded material, including files deleted from a user's account but not erased, may be monitored or read by school officials.

Internet Safety

Each District computer with Internet access shall have a filtering device that blocks entry to visual depictions that are: (1) obscene, (2) pornographic, or (3) harmful or inappropriate for students, as defined by federal law and as determined by the Superintendent or designee. The Superintendent or designee shall enforce the use of such filtering devices. An administrator, supervisor, or other authorized person may disable the filtering device for bona fide research or other lawful purpose, provided the person receives prior permission from the Superintendent or system administrator. The Superintendent or designee shall include measures in this policy's implementation plan to address the following:

1. Ensure staff supervision of student access to online electronic networks,
2. Restrict student access to inappropriate matter as well as restricting access to harmful materials,
3. Ensure student and staff privacy, safety, and security when using electronic communications,
4. Restrict unauthorized access, including "hacking" and other unlawful activities, and
5. Restrict unauthorized disclosure, use, and dissemination of personal identification information, such as, names and addresses.

Authorization for Electronic Network Access

Each staff member must sign the District's *Authorization for Electronic Network Access* as a condition for using the District's electronic network. Each student and his or her parent(s)/guardian(s) must sign the *Authorization* before being granted unsupervised use.

All users of the District's computers to access the Internet shall maintain the confidentiality of student records. Reasonable measures to protect against unreasonable access shall be taken before confidential student information is loaded onto the network.

The failure of any student or staff member to follow the terms of the *Authorization for Electronic Network Access*, or this policy, will result in the loss of privileges, disciplinary action, and/or appropriate legal action.

LEGAL REF.: No Child Left Behind Act, 20 U.S.C. §6777.
Children's Internet Protection Act, 47 U.S.C. §254(h) and (l).
Enhancing Education Through Technology Act, 20 U.S.C §6751 et seq.
720 ILCS 135/0.01.

CROSS REF.: 5:100 (Staff Development Program), 5:170 (Copyright), 6:40 (Curriculum Development), 6:210 (Instructional Materials), 6:230 (Library Resource Center), 6:260 (Complaints About Curriculum, Instructional Materials, and Programs), 7:130 (Student Rights and Responsibilities), 7:190 (Student Discipline), 7:310 (Restrictions on Publications and Written or Electronic Material)

ADMIN PROC.: 6:235-AP (Administrative Procedure - Acceptable Use of Electronic Networks), 6:235-E2 (Exhibit - Authorization for Electronic Network Access

Network Access Agreement

Purpose

Computer use has become an essential part of many school activities. Computers are used to support learning and to enhance instruction and computer networks allow people to interact with many computers. The Northwest Suburban Special Education Organization (NSSEO) has the ability to enhance students' education through the use of computers. Network access is available to students and staff members at NSSEO. We believe this offers vast, diverse and unique resources to both students and staff. Our goal in providing this service to staff and students is to promote educational excellence in schools by facilitating resource sharing, innovation, and communication.

With this opportunity comes responsibility. Proper use of technology resources is a joint responsibility of students, parents, and employees of NSSEO. It is a general policy that all computers are to be used in a responsible, efficient, ethical, and legal manner. Failure to adhere to the policy and guidelines may result in the revocation of the user's access privilege or other disciplinary action. Access to computing resources is a privilege to which all faculty, staff, and students are entitled. Certain responsibilities accompany that privilege. Understanding these responsibilities is important for the users. It should be noted that NSSEO complies with CIPA (Children's Internet Protection Act) requirements, which includes enforcing an Internet Safety Policy and that includes a Technology Protection Measure, including monitoring the online activities of minors.

- NSSEO blocks and filters Internet Access to pictures that are: (a) obscene, (b) child pornography, or (c) harmful to minors.
- Online activities of minors are monitored by staff members.
- Access by minors to inappropriate matter in the Internet is monitored through the use of filters/blocking software and supervision of students by staff members.
- The safety and security of minors when using electronic mail, chat rooms, and other forms of direct electronic communications is provided through the use of filters/blocking software and staff supervision.
- Unauthorized access, including so-called "hacking," and other unlawful activities by minors online are prohibited.
- Unauthorized disclosure, use, and dissemination of personal information regarding minors are prohibited.
- Access to harmful materials on the internet is restricted through use of filtering/blocking software and through supervision of students by staff members.

Use of Local Area Network, Wide Area Network and Internet

Definitions

The Northwest Suburban Special Education Organization (NSSEO) provides access to educational and informational resources for Users through computers connected to local area networks (LANs). These networks may be connected to the district's wide area network (WAN) and to the internet. The internet is a worldwide network of computers and provides access to electronic mail (e-mail), databases, software, discussion groups, and other informational services. Internet service is provided through a third party service provider. In addition to the LAN/WAN system, access to the internet may also be provided via dial access modems. For the purpose of this document, the LAN/WAN/Internet system is referred to as the "Network", whether accesses via a direct LAN/WAN connection or modem from within or outside the District facility. The term "User" applies to anyone accessing the Network for any purpose.

User Responsibility

The following guidelines have been established to help ensure responsible and productive Network usage.

1. All use of the Network must be in support of educational and research consistent with the mission of NSSEO.
2. Private information about students and school staff is not to be transmitted over the internet, including social security numbers or credit card numbers.
3. Accessing, submitting, posting, publishing, or displaying any abusive, profane, discriminatory, offensive, obscene, harassing, threatening, intimidating, or disruptive messages or images to any User or other person is prohibited. Examples of unacceptable content may include, but are not limited to, sexual comments or images, racial slurs, gender-specific comments, or any other comments or images that could reasonably offend someone on the basis of race, age, sex, religion or political beliefs, national origin, disability, sexual orientation, or any other characteristic protected by law.
4. Any use of a Network for commercial or for-profit purposes is prohibited.
5. Extensive use of the Network for personal and private business is prohibited.
6. Any use of the Network for product advertisement, political lobbying, religious activities, gambling, chain letters, or pyramid schemes is prohibited.
7. Users shall not intentionally seek information on, obtain copies of, or modify files, other data or passwords belonging to other users, or misrepresent other users on a network.
8. All communication and information accessible on the Network should be assumed to be public information that would be accessible via the Freedom of Information Act.
9. No use of a network shall serve to disrupt the use of the Network by others; hardware or software shall not be destroyed, modified, or abused in any way.
10. Malicious use of the Network to develop programs that harass other users or infiltrate a computer or computing system and/or damage the software components of a computer or computing system is prohibited.
11. Hate mail, harassment, discriminatory remarks, and other antisocial behaviors are prohibited on the Network.
12. The illegal installation, duplication, or distribution of copyrighted software on a school district computer or the illegal transfer of software over a network is prohibited
13. Unauthorized downloading of software, files, or images is prohibited. This includes downloading any program, partial program or game without the express approval of the NSSEO Coordinator of Technology or NSSEO Network Manager.

14. Use of the Network to access or process pornographic material, inappropriate text files, or files dangerous to the integrity of the Network is prohibited.
15. Transmission of any material in violation of any U.S. or state regulation is prohibited (e.g. copyrighted material, threatening or obscene material, or material protected by trade secrets).
16. NSSEO reserves the right to log Network/Internet use and to monitor file server space utilized by Users.
17. Using the Network while access privileges are suspended or revoked is prohibited.

Network Etiquette

You are expected to abide by the generally accepted rules of Network etiquette. These include, but are not limited to, the following:

1. Be polite. Do not become abusive in your messages to others.
2. Use appropriate language. Do not swear, use vulgarities or any inappropriate language.
3. Illegal activities are strictly prohibited.
4. Do not reveal the personal addresses or telephone numbers of students or employees.
5. Recognize that electronic mail (E-mail) is not private. People who operate the system have access to all mail. Messages relating to or in support of inappropriate activities will be reported.
6. Do not use the Network in any way that would disrupt its use by others.
7. Consider all communications and information accessible via the Network to be private property of NSSEO.

Disclaimer

NSSEO is providing a conduit to information and is not responsible for the information that is retrieved from outside sources. This includes the loss of data resulting from delays, nondeliveries, misdeliveries, or service interruptions caused by the User's negligence, errors, or omissions. Use of information obtained via the Internet is at your own risk. NSSEO denies any responsibility for the accuracy or quality of information obtained, or for any unauthorized financial obligations resulting from the use of school resources and accounts to access the Internet.

This Authorization does not attempt to state all required or prescribed behavior by users. **The failure to follow the terms of the Network Access Agreement will result in the loss of privileges, disciplinary action and/or appropriate legal action**. The signature(s) at the end of this document is legally binding and indicates the party that signed has read the terms and conditions carefully and understands their significance.

Employee Authorization for Network Access

Employees have the privilege to use computer workstations in order to facilitate student growth in technology skills, information gathering skills, and communication skills, and to perform administrative tasks. These workstations may provide access to the Internet. Only those employees with prior experience and instruction shall be authorized to use the network and Internet access. Employees have a professional responsibility to ensure appropriate use of technology by students. Employees will monitor all students Internet use as thoroughly as possible. Each classroom should have a dedicated computer area. This area is to be used strictly for computer equipment. Failure to keep this area organized could result in removal of complete computer equipment.

I have read the Northwest Suburban Special Education Organization's **Network Access Agreement** document and agree to abide by it, and to uphold my responsibilities as an employee user of NSSEO's computers and networks. I further understand that should I commit any violation, my access privileges may be revoked and school disciplinary action, up to and including dismissal from employment, and/or appropriate legal action may be taken. In consideration for using NSSEO's Internet connection and having access to public networks, I hereby release the Northwest Suburban Special Education Organization and its Board members, and agents from any claims and damages arising from my use, or inability to use the Internet.

Employee Name: _____ Building: _____

Employee Signature: _____ Date: _____

799 West Kensington Rd., Mount Prospect, IL 60056-1111 ● Ph: 847.463.8100 • Fax 847.463.8121 ● TDD: 847.463.8115 ● www.nsseo.org

Employee Laptop Agreement

As a borrower of an NSSEO laptop, I accept the following responsibilities:

- I will follow the guidelines established in the NSSEO **Network Access Agreement** and I have signed the **Employee Authorization for Network Access**.
- I will follow the guidelines listed below for proper care of the laptop.
- I will use the computer for school or professional development purposes. I will not install any software on the computer unless it has been approved by the school's technology coordinator. (Requests for software modification or installation should be made 7 days in advance of when they are needed.)
- I will not write on or place any labels or stickers on the laptop.
- I will not disable or uninstall the virus protection program that is provided with the machine.
- I will ensure any documents I create will be moved from the laptop to the network on a monthly basis for backup purposes.
- I will bring the laptop back to school and log in to the network at least once a month in order to ensure that antivirus software and other updates pushed out through the network are current.
- I will report any problems/issues I encounter while using the laptop to the technology department immediately through the help desk. (E-mail helpdesk@nsseo.org)
- I understand that the technology staff will reimage the laptop at any point where it becomes unusable or unstable and at the end of the year.
- I understand that reimaging may be a course of action for any repairs or modifications on the computer and this will result in the loss of all data from the laptop.
- Any modifications I make in the computer's settings will be for usability or cosmetic reasons only.
- All laptops must be returned at the end of the school year for inventory and software updates. Laptops will be reassigned as deemed appropriate by the administration.

Guidelines for Proper Care of the Laptop

1. The laptop is not to be loaned to anyone.
2. Other individuals, including children, should not be allowed to play on the computer.
3. Proper care is to be given to the laptop at all times, including but not limited to the following:
    a. Give care appropriate for any electrical device.
    b. Use a surge protector or unplug the laptop during electrical storms.
    c. Keep food and drink away from the computer.
    d. Do not leave the laptop exposed to direct sunlight or extreme cold.
    e. Position the laptop on a safe surface so it does not drop or fall.
    f. Do not attempt to repair a damaged or malfunctioning laptop.
    g. Do not attempt to upgrade the computer or software.
4. Proper security is to be provided for the laptop at all times, including, but not limited to, the following:
    a. Secure your laptop in a safe place at the end of the day.
    b. Do not leave the laptop in an unlocked car.
    c. Do not leave the A/C adapter behind when moving the laptop.

Laptop Acceptance Form

Date: _____ Asset Tag Number: _____

Name: _____

Program: _____ Work Phone Number: _____

Date Assigned: _____ Date to be Returned: _____

I understand that all laptop computers, equipment, and/or accessories that the cooperative has provided to me are the property of the Northwest Suburban Special Education Organization. I agree to the terms outlined in the cooperative's Employee Laptop Agreement and the Network Access Agreement.

I understand that I will report any damage, loss, or theft of the laptop computer to the Technology Coordinator or NSSEO Administration. Additionally, I understand that I will not be held responsible for computer problems resulting from regular school-related use; however, I understand that I am personally responsible for any damage, theft, or loss of the laptop computer and/or related equipment and accessories due to negligence.

I understand that a violation of the terms and conditions set out in the Employee Laptop Agreement and the Network Access Agreement will result in the restriction and/or termination of my use of the cooperative's laptop computers, equipment, and/or accessories and may result in further discipline up to and including termination of employment and/or legal action.

Items Loaned/Condition

Item	Loaned		Condition	
Laptop Computer	Yes	No	New	Used
Power Supply and Cord	Yes	No	New	Used
Laptop Case	Yes	No	New	Used

Comments: (overall condition, scratches, dents, etc.)

Signature: _____ Date: _____

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Northwest Suburban Special Education Organization

Judith A. Hackett Ed.D., Superintendent

TECHNOLOGY DEVICE RETURN PROCEDURE

For Staff Not Returning to NSSEO and Staff Transferring To Other Programs Within NSSEO

All of the following items must be turned in on or before the employee's last day of employment.

1. Technology Devices

   ___laptops ___pagers
   ___palm pilots ___personal communicators
   ___cell phones ___other instructional devices: _____

   All personal information should be removed from these systems by the employee. Data migration needs to be accomplished prior to turn-in as devices will be erased and started anew. Devices should be turned in to the program Tec Liaison. At that point, all program and student-related information will be transferred to the program administrator.

   For employees transferring from one NSSEO program to another, they must turn in their current program equipment as specified above.

2. Building Keys and Security Cards
   These should be turned in to the program administrator.

3. E-Mail
   User rights will be terminated at midnight on the employee's last day of employment. Exceptions can be made for staff members remaining to teach summer school when the program administrator submits this extension request to the Tec Help Desk Operator prior to the last day of the regular school year.

4. Phone lines and voice mail boxes assigned to individual staff members will be terminated at midnight on the employee's last day of employment.

ADMINISTRATIVE GUIDELINES FOR NOTIFYING THE TECHNOLOGY DEPARTMENT

Of Staff Not Returning to NSSEO and Staff Transferring To Other Programs Within NSSEO

A) For employees terminating or transferring service (voluntary or involuntary) prior to the end of the school year, Human Resources will notify the Technology Dept. in writing of the employee's name, program and last day of employment, as soon as possible, preferably at least 2 weeks prior to the last day of employment.

B) For employees terminating or transferring service at the end of the school year (voluntary or involuntary), Human Resources will notify the Technology Dept. with the same information specified in Part A.

C) The decision to re-issue the same equipment will be made by the appropriate program administrator by contacting the Technology Dept.

D) Unless an employee is being immediately terminated, the Technology Dept. will send out written notice to each departing employee at least 2 weeks prior to the last day of employment that e-mail access will end at midnight on the last day of employment. In this notice, employees will be instructed that if they need assistance cleaning out their e-mail, voice mail, computer, cell phone or other personal communication devices, they should contact their program Tec Liaison.

E) Phone lines of non-returning staff will be forwarded to the main office in that building by the Technology Dept. until that line has been re-assigned.

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NSSEO

Northwest Suburban Special Education Organization

Health Insurance Plan Documents

Blue Cross Blue Shield PPO
Blue Cross Blue Shield HMO of IL
Group Administrators Dental PPO
Guardian/1st Commonwealth Dental HMO

Notice to Enrollees in the Northwest Suburban Special Education PPO Medical Plan

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits state and local government employers that sponsor health plans to elect to exempt a plan from these requirements for part of the plan that is "self-funded" by the employer, rather than provided through an insurance policy.

Northwest Suburban Special Education Organization has elected to exempt its PPO medical plan from of the following requirements:

Parity in the application of certain limits to mental health benefits.
Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance abuse benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The exemption from these Federal requirements will be in effect for the plan year beginning 7/1/2011 and ending 6/30/2012. The election may be renewed for subsequent plan years.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

Kim Cowles
NSSEO Insurance
799 West Kensington Road
Mt. Prospect, IL 60013
847-463-8127
kcowles@nsseo.org

Women's Health and Cancer Rights Act Annual Notice

On October 21 1998 Congress passed a bill called the *Women's Health and Cancer Rights Act.* This new law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed,
- Surgery/reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Physical complications during all stages of mastectomy, including lymph edemas

In addition, the plan may not:

- interfere with a woman's rights under the plan to avoid these requirements, or-
- offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles and copays consistent with other coverage provided by the plan.

If you have any questions about the current plan coverage, please contact Kim Cowles, at 847.463.8127.

FY 2011-2012

Building a promising future for students

NSSEO

Northwest Suburban Special Education Organization

Judith A. Hackett Ed.D., Superintendent

September 14, 2011

All Medical Insured Employees and Covered Dependents of Medicare Age:

On December 8, 2003, President Bush signed into law the Medicare Prescription Drug, Improvement and Modernization Act (MMA). The new law established a prescription drug discount card for 2004 and 2005 and prescription drug coverage for Medicare Eligible beneficiaries (Medicare Part D) that started in January 1, 2006.

Medicare has been offering insurance coverage for prescription drugs through Medicare Part D starting on January 1, 2006. Insurance companies and other private companies will work with the Centers for Medicare Services (CMS) to offer these plans to employees and covered dependents of Medicare age.

The purpose of this letter is to inform you that Northwest Suburban Special education Organization will continue to offer prescription drug coverage under the benefit plan and the coverage is "creditable coverage". "Creditable coverage" means the District's prescription drug plan provides more coverage than Medicare Part D. A Certificate of Creditable Coverage from the District is enclosed. Medicare eligible employees and covered dependents receiving creditable coverage can join Medicare Part D in the future without paying the higher late enrollment fees.

NSSEO currently provides prescription drug coverage through Medco for our PPO plan and Prime Therapeutics for our HMO plan.

Please feel free to contact Kim Cowles at (847) 463-8127 with any questions.

Sincerely,
Kimberly Cowles
NSSEO Insurance Department

Important Notice from Northwest Suburban Special Education Organization (NSSEO) about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with NSSEO and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.
There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. NSSEO has determined that the prescription drug coverage offered by the NSSEO Health Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current NSSEO coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current NSSEO coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with NSSEO and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through NSSEO changes. You also may request a copy of this notice at any time.

NSSEO offers prescription drug coverage through Medco for our PPO plan and Prime Therapeutics for our HMO plan.

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	9/15/2011
Name of Entity/Sender:	Northwest Suburban Special Education Organization Julie Jilek
Contact--Position/Office:	Director of Business Services & Building Facilities
Address:	799 W. Kensington Road Mt. Prospect, IL 60056
Phone Number:	847-463-8100

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

PPO
Medical Benefit Summary

Northwest Suburban Special Education Organization
NSSEO

Northwest Suburban Special Education Organization

Your Health Care Benefit Program

Educational Benefit Cooperative

P99735

A message from

Northwest Suburban Special Education Organization

This booklet describes the Health Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your healthcare claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the Employee Benefits Department.

Sincerely,

Northwest Suburban Special Education Organization

NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled "Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

LIMITED BENEFITS FOR NON-PARTICIPATING PROVIDERS

You should be aware that when you elect to receive Covered Services from a Non-Participating Professional Provider in non-emergency situations, the amount of the benefit payment to such Non-Participating Professional Provider will be a reduced benefit payment that would have been made if services had been rendered by a Participating Professional Provider and not the actual billed charge. **In certain cases, you can expect to pay in excess of 50% of the Non-Participating Professional Provider's billed charge even after the Claim Administrator has paid the Maximum Allowance under your coverage.** Participating Professional Providers have agreed to accept the Maximum Allowance (please refer to the definition of "Maximum Allowance") with no additional billing after you have paid your Coinsurance and deductible amount.

You may obtain further information about the participating status of Professional Providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

TABLE OF CONTENTS

BENEFIT HIGHLIGHTS

Your health care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet.

THE UTILIZATION REVIEW PROGRAM	A special program designed to assist you in determining the course of treatment that will maximize your benefits under this benefit booklet
Lifetime Maximum for all Benefits	$5,000,000
Individual Deductible	$350 per benefit period
Family Deductible	$700 per benefit period
Individual Out-of-Pocket Expense Limit **(does not apply to all services)**	$1,000 per benefit period
Family Out-of-Pocket Expense Limit	$2,000 per benefit period
Private Duty Nursing Service Benefit Maximum	$3,000 per month
Routine Vision Examination Benefit Maximum	$50 per benefit period
Wellness Care Benefit Maximum	$500 per benefit period
Lifetime Maximum Outpatient Substance Abuse Rehabilitation Treatment	$22,500
Lifetime Maximum Inpatient Substance Abuse Rehabilitation Treatment	$27,500
Lifetime Maximum Outpatient Treatment of Mental Illness	225 visits
Lifetime Maximum Inpatient Treatment of Mental Illness	40 days
SUPPLEMENTAL ACCIDENT CARE	
Benefit Payment Level	$500 maximum per accident

HOSPITAL BENEFITS

Payment level for Covered Services from a **Participating Provider:**	
— Inpatient Covered Services	80% of the Eligible Charge
— Outpatient Covered Services	80% of the Eligible Charge
— Outpatient Diagnostic Services	100% of the Eligible Charge up to the first $200 per benefit period and your program deductible will not apply. Thereafter, benefitswill be provided at 80% of theEligible Charge after you have met your program deductible
— Wellness Care	100% of the Eligible Charge, no deductible
— Outpatient Treatment of Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	80% of the Eligible Charge
Payment level for Covered Services from a **Non-Participating Provider:**	
— Inpatient Covered Services	70% of the Eligible Charge
— Outpatient Covered Services	70% of the Eligible Charge
— Outpatient Diagnostic Services	100% of the Maximum Allowance up to the first $200 per benefit period and your program deductible will not apply. Thereafter, benefits will be provided at 70% of the Maximum Allowance after you have met your program deductible
— Wellness Care	100% of the Eligible Charge, no deductible
— Outpatient Treatment of Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	70% of the Eligible Charge
Payment level for Covered Services from a **Non-Administrator Provider**	50% of the Eligible Charge

HOSPITAL EMERGENCY CARE

Payment level for Emergency Accident Care

— Participating Provider	80% of the Eligible Charge
— Non-Participating or Non-Administrator Provider	70% of the Eligible Charge

Payment level for Emergency Medical Care

— Participating Provider	80% of the Eligible Charge
— Non-Participating or Non-Administrator Provider	70% of the Eligible Charge

PHYSICIAN BENEFITS

Payment level for Surgical/ Medical Covered Services

— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	70% of the Maximum Allowance

Payment level for Outpatient Diagnostic Service

— Participating Provider	100% of the Maximum Allowance up to the first $200 per benefit period and your program deductible will not apply. Thereafter, benefits will be provided at 80% of the Maximum Allowance after you have met your program deductible
— Non-Participating Provider	100% of the Maximum Allowance up to the first $200 per benefit period and your program deductible will not apply. Thereafter, benefits will be provided at 70% of the Maximum Allowance after you have met your program deductible

Payment level for Emergency Accident Care

— Participating Provider	80% of the Eligible Charge
— Non-Participating Provider	70% of the Eligible Charge

Payment level for Emergency Medical Care

— Participating Provider	80% of the Eligible Charge
— Non-Participating Provider	70% of the Eligible Charge

Additional Surgical Opinion	100% of the Claim Charge, no deductible
Payment level for Wellness Care	
— **Participating Provider**	100% of the Maximum Allowance, no deductible
— **Non-Participating Provider**	100% of the Maximum Allowance, no deductible
Payment level for Outpatient Treatment of Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	
— **Participating Provider**	80% of the Maximum Allowance
— **Non-Participating Provider**	70% of the Maximum Allowance
OTHER COVERED SERVICES	
Payment level	80% of the Eligible Charge or Maximum Allowance

TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR IDENTIFICATION CARD.

DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

ADMINISTRATOR PROGRAM.....means programs for which a Hospital has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Program or Coordinated Home Care Program.

ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

ADVANCED PRACTICE NURSE.....means Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.

AMBULANCE TRANSPORTATION.....means local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

An ''Administrator Ambulatory Surgical Facility'' means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A ''Non-Administrator Ambulatory Surgical Facility'' means an Ambulatory Surgical Facility which does not meet the definition of an Administrator Ambulatory Surgical Facility.

ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

AVERAGE DISCOUNT PERCENTAGE ("ADP").....means a percentage discount determined by the Claim Administrator that will be applied to a Provider's Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.") In determining the ADP applicable to a particular Claim, the Claim Administrator will take into account differences among Hospitals and other facilities, the Claim Administrator's contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under the Health Care Plan are secondary to Medicare and/or coverage under any other group program.

CERTIFICATE OF CREDITABLE COVERAGE.....means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program for purposes of reducing any Preexisting Condition exclusion imposed by any group health plan coverage.

CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of an advanced practice nursing program.

A ''Participating Certified Clinical Nurse Specialist" means a Certified Clinical Nurse Specialist who has a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A ''Non-Participating Certified Clinical Nurse Specialist" means a Certified Clinical Nurse Specialist who does not have a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

A ''Participating Certified Nurse-Midwife" means a Certified Nurse-Midwife who has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered.

A ''Non-Participating Certified Nurse-Midwife" means a Certified Nurse-Midwife who does not have a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered.

CERTIFIED NURSE PRACTITIONER.....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act**;** (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of an advanced practice nursing program.

A ''Participating Certified Nurse Practitioner" means a Certified Nurse Practitioner who has a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A ''Non-Participating Certified Nurse Practitioner" means a Certified Nurse Practitioner who does not have a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA.....means a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors: (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every tow years by the Council on Recertification of Nurse Anesthetists.

A ''Participating Certified Registered Nurse Anesthetist" means a Certified Registered Nurse Anesthetist who has a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Registered Nurse Anesthetist" means a Certified Registered Nurse Anesthetist who does not have a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

CHEMOTHERAPY.....means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

CHIROPRACTOR.....means a duly licensed chiropractor.

CLAIM.....means notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

CLAIM PAYMENT.....means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

CLINICAL LABORATORY.....means a clinical laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

A "Participating Clinical Laboratory" means a Clinical Laboratory which has a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered.

A "Non-Participating Clinical Laboratory" means a Clinical Laboratory which does not have a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered.

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

COINSURANCE..... means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COMPLICATIONS OF PREGNANCY.....means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

An ''Administrator Coordinated Home Care Program'' means a Coordinated Home Care Program which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide service to you at the time service is rendered to you.

A ''Non-Administrator Coordinated Home Care Program'' means a Coordinated Home Care Program which does not have an agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT..... means a specified dollar amount that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under the Health Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

CREDITABLE COVERAGE .....means coverage you had under any of the following:

(i) a group health plan.

(ii) Health insurance coverage for medical care under any hospital or medical service policy plan, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

(iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).

(iv) Medicaid (Title XIX of the Social Security Act).

(v) Medical care for members and certain former members of the uniformed services and their dependents.

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool.

(viii) A health plan offered under the Federal Employees Health Benefits Program.

(ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.

(x) A health plan under Section 5(e) of the Peace Corps Act.

(xi) State Children's Health Insurance Program (Title XXI of the Social Security Act).

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

DENTIST.....means a duly licensed dentist.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis

on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

An ''Administrator Dialysis Facility'' means a Dialysis Facility which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A ''Non-Administrator Dialysis Facility'' means a Dialysis Facility which does not have an agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state but has been certified in accordance with the guidelines established by Medicare.

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider.

A ''Participating Durable Medical Equipment Provider'' means a Durable Medical Equipment Provider who has a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A ''Non-Participating Durable Medical Equipment Provider'' means a Durable Medical Equipment Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

ELIGIBLE CHARGE.....means (a) in the case of a Provider other than a Professional Provider which has a written agreement with the Claim Administrator to provide care to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider other than a Professional Provider which does not have a written agreement with the Claim Administrator to provide care to you at the time Covered Services are rendered, the amount for Covered Services as determined by the Claim Administrator based on the following order:

(i) the charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services, as reasonably determined by the Claim Administrator, if available,

(ii) the amount that the Centers for Medicare & Medicaid Services (“CMS”) reimburses the Hospitals or facilities in similar geographic areas for the same or similar services rendered to members in the Medicare program, or

(iii) the charge which the particular Hospital or facility usually charges its patients for Covered Services.

ELIGIBLE PERSON.....means an employee of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this benefit booklet.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Services.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of the sudden and unexpected onset of a medical condition that the absence of immediate medical attention would likely result in serious and permanent medical consequences.

Examples of medical conditions are: severe chest pains, convulsions or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS ADMISSION....means an admission for the treatment of Mental Illness as a result of the sudden and unexpected onset of a mental condition that the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

Examples of Mental Illness are: major depression with significant suicidal intent, psychosis with associated homicidal intent or a manic episode resulting in inability to care for oneself.

EMPLOYER.....means the company with which you are employed.

ENROLLMENT DATE.....means the first day of coverage under your Employer's health plan or, if your Employer has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins).

ENROLLMENT PERIOD.....means the period specified in the Benefit Program Application during which you may apply for coverage if you did not apply prior to your Eligibility Date or if you did not apply for Family Coverage when eligible to do so.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Health Care Plan.

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider.

A ''Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who has a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A ''Non-Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service.

HOSPICE CARE PROGRAM SERVICE.....means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

HOSPITAL.....means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

An ''Administrator Hospital'' means a Hospital which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A ''Non-Administrator Hospital'' means a Hospital that does not meet the definition of an Administrator Hospital.

A ''Participating Hospital'' means an Administrator Hospital that has an agreement with the Claim Administrator to provide Hospital services to participants in the Participating Provider Option program.

A ''Non-Participating Hospital'' means an Administrator Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under the Health Care Plan for yourself but not your spouse and/or dependents.

INPATIENT.....means that you are a registered bed patient and are treated as such in a health care facility.

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST ("LMFT").....means a duly licensed marriage and family therapist.

A "Participating Marriage and Family Therapist" means a Marriage and Family Therapist who has a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered.

A "Non-Participating Marriage and Family Therapist" means a Marriage and Family Therapist who does not have a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MAXIMUM ALLOWANCE.....means the amount determined by the Claim Administrator which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Professional Providers, whether Participating or Non-Participating will be based on the Schedule of Maximum Allowances. These amounts may be amended from time to time by the Claim Administrator.

MEDICAL CARE.....means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY.....SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

MEDICARE SECONDARY PAYER or MSP.....means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

MENTAL HEALTH UNIT.....means a unit established to perform preadmission review and length of stay review for Inpatient and/or Outpatient services for the treatment of Mental Illness and Substance Abuse.

MENTAL ILLNESS.....means those illnesses classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

NAPRAPATH.....means a duly licensed naprapath.

NAPRAPATHIC SERVICES.....means the performance of naprapathic practice by a Naprapath which may legally be rendered by them.

NON-ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist.

OCCUPATIONAL THERAPY.....means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST.....means a duly licensed optometrist.

A ‘‘Participating Optometrist” means an Optometrist who has a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A “Non-Participating Optometrist” means an Optometrist who does not have a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider.

A ‘‘Participating Orthotic Provider” means an Orthotic Provider who has a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A ''Non-Participating Orthotic Provider" means an Orthotic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Claim Administrator approved planned program of a Hospital or Substance Abuse Treatment Facility for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in which patients spend days or nights.

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PARTICIPATING PRESCRIPTION DRUG PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER OPTION.....means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

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

PHYSICAL THERAPIST.....means a duly licensed physical therapist.

PHYSICAL THERAPY.....means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

PODIATRIST.....means a duly licensed podiatrist.

PREEXISTING CONDITION.....means any disease, illness, sickness, malady or condition which medical advice, diagnosis, care or treatment was received or recommended by a Provider within 6 months prior to your Enrollment Date. Taking prescription drugs is considered medical treatment even if your condition was diagnosed more than 6 months before your Enrollment Date. For purposes of this definition, pregnancy or conditions based solely on genetic information are not preexisting conditions.

PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider.

A ''Participating Prosthetic Provider'' means a Prosthetic Provider who has a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A ''Non-Participating Prosthetic Provider'' means a Prosthetic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you.

An ''Administrator Provider'' means a Provider which has a written agreement with the Claim Administrator to provide services to you at the time services are rendered to you.

A ''Non-Administrator Provider'' means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

A ''Participating Provider'' means an Administrator Hospital or Professional Provider which has a written agreement with the Claim Administrator to provide services to participants in the Participating Provider Optionprogram or an Administrator facility which has been designated by the Claim Administrator as a Participating Provider.

A ''Non-Participating Provider'' means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claim Administrator to provide services to participants in the Participating Provider

Option program or a facility which has not been designated by the Claim Administrator as a Participating Provider.

A ''Professional Provider'' means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, Clinical Social Worker or any Provider designated by the Claim Administrator.

A ''Participating Prescription Drug Provider'' means a Pharmacy that has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer its prescription drug program to provide services to you at the time you receive the services.

PSYCHOLOGIST.....means a Registered Clinical Psychologist.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Financial and Professional Regulation pursuant to the Illinois ''Psychologists Registration Act'' or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant.

A ''Participating Registered Surgical Assistant'' means a Registered Surgical Assistant who has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered.

A ''Non-Participating Registered Surgical Assistant'' means a Registered Surgical Assistant who does not have a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered.

RENAL DIALYSIS TREATMENT.....means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

RESPITE CARE SERVICE.....means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services to you.

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

An "Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A "Non-Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which does not have an agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state but has been certified in accordance with guidelines established by Medicare.

An "Uncertified Skilled Nursing Facility" means a Skilled Nursing Facility which does not meet the definition of an Administrator Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

SKILLED NURSING SERVICE.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

SPEECH THERAPIST.....means a duly licensed speech therapist.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

SUBSTANCE ABUSE.....means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or Psychologist.

SUBSTANCE ABUSE REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting

primarily of counseling by individuals other than a Physician or Psychologist, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE ABUSE TREATMENT FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

An ''Administrator Substance Abuse Treatment Facility'' means a Substance Abuse Treatment Facility which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A ''Non-Administrator Substance Abuse Treatment Facility'' means a Substance Abuse Treatment Facility that does not meet the definition of an Administrator Substance Abuse Treatment Facility.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TOTALLY DISABLED.....means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

ELIGIBILITY SECTION

This benefit booklet contains information about the Health Care Plan for persons who meet the definition of an Eligible Person as determined by your Employer.

If you meet this definition of an Eligible Person, have applied for this coverage and have received an ID card, then you are entitled to the benefits described in this benefit booklet.

MEDICARE ELIGIBLE COVERED PERSONS

If you meet the definition of an Eligible Person stated in the ELIGIBILITY Section above and you are eligible for Medicare and not affected by the ''Medicare Secondary Payer'' (MSP) laws as described below, the benefits described in the section of this benefit booklet entitled ''Benefits for Medicare Eligible Covered Persons'' will apply to you and to your spouse and covered dependent children (if he or she is also eligible for Medicare and not affected by the MSP laws).

A series of federal laws collectively referred to as the ''Medicare Secondary Payer'' (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan ("GHP") coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

1. GHPs that cover individuals with end-stage renal disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has "current employment status."
2. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

PLEASE NOTE: SEE YOUR EMPLOYER OR GROUP ADMINISTRATOR SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ESRD PRIMARY PERIOD OR OTHER PROVISIONS OF MSP LAWS AND THEIR APPLICATION TO YOU, YOUR SPOUSE OR ANY DEPENDENTS.

YOUR MSP RESPONSIBILITIES

In order to assist your employer in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Claim Administrator and/or your employer regarding the Medicare eligibility of you, your spouse and covered dependent children. In addition, if you, your spouse or covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your employer or your group administrator promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

YOUR ID CARD

You will receive a identification card. This card will tell you your identification number and will be very important to you in obtaining your benefits.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own expenses for Covered Services are covered, not the expenses of other members of your family.

FAMILY COVERAGE

If you have Family Coverage, your expenses for Covered Services and those of your enrolled spouse and your (or your spouse's) enrolled unmarried children who are under age 19 will be covered. Enrolled unmarried children who are full-time students will be covered up to age 23. The coverage for unmarried children will end on the birthday.

Any newborn children will be covered from the moment of birth. Please notify your Group Administrator within 31 days of the date of birth so that your membership records can be adjusted.

Any children who are incapable of self-sustaining employment and are dependent upon you or other care providers for lifetime care and supervision because of a handicapped condition occurring prior to reaching the limiting age will be covered regardless of age if they were covered prior to reaching the limiting age stated above.

Any children who are under your legal guardianship or who are in your custody under an interim court order of adoption or who are placed with you for adoption vesting temporary care will be covered.

This coverage does not include benefits for grandchildren (unless such children are under your legal guardianship) or foster children.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO FAMILY COVERAGE

You can change from Individual to Family Coverage or add dependents to your Family Coverage because of any of the following events:

- Marriage.
- Birth, adoption or placement for adoption of a child.

- Obtaining legal guardianship of a child.
- Loss of eligibility for other health coverage for you or your dependent if:
    a. The other coverage was in effect when you were first eligible to enroll for this coverage;
    b. The other coverage is not terminating for cause (such as failure to pay premiums or making a fraudulent claim); and
    c. Where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment in this coverage.

  This includes, but is not limited to, loss of coverage due to:
    a. Legal separation, divorce, cessation of dependent status, death, termination of employment, or reduction in the number of hours of employment;
    b. In the case of HMO coverage, moving out of the HMO service area;
    c. Reaching a lifetime limit on all benefits in another group health plan; or
    d. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent.
- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

When Coverage Begins

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 31 days of any of the following events:

- Marriage.
- Birth, adoption, or placement of adoption of a child.
- Obtaining legal guardianship of a child.

Your Family Coverage or the coverage for your additional dependents will be effective from the date you apply for coverage if you apply within 31 days of any of the following events:

- Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.
- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

If coverage is lost in another group health plan because a lifetime limit on all benefits is reached under that coverage and you apply for Family Coverage or to add dependents within 31 days after a claim is denied due to reaching the lifetime limit, your Family Coverage or the coverage for your additional dependents will be effective from the date your claim was denied.

Late Applicants

If you do not apply for Family Coverage or to add dependents within 31 days of the event, you will have to wait until your Employer's annual open enrollment period to make those changes. Your dependents will then be subject to the 546 days Preexisting Condition waiting period as described in the Preexisting Condition Waiting Period provision of this benefit section. Such changes will be effective on a date that has been mutually agreed to by your Employer and the Claim Administrator.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

Should you wish to change from Family to Individual Coverage, please contact your Human Resources Department.

PREEXISTING CONDITION WAITING PERIOD

Your benefits (other than for Maternity Services) are subject to a Preexisting Condition waiting period of 365 days. The Preexisting Condition waiting period will begin on the Enrollment Date for you and your eligible dependents (if Family Coverage is effective) and will continue for the number of days specified. This Preexisting Condition waiting period will also apply to each dependent (other than a newborn child, an adopted child under age 18, or a child under age 18 placed for adoption or a child under your legal guardianship if the child is enrolled within 31 days of birth, adoption, placement of adoption or legal guardianship) for whom coverage is applied for after your Coverage Date. The Preexisting Condition waiting period for such a dependent will begin on the dependent's Enrollment Date.

However, benefits for those persons who do not apply for coverage when first eligible to do so are subject to a Preexisting Condition waiting period of 546 days.

If you had health coverage prior to getting this coverage without a break in coverage of 63 days or more, your Preexisting Condition waiting period is reduced by the length of time you had Creditable Coverage. You have the right to request a Certificate of Creditable Coverage from any previous health plan or insurer. The Claim Administrator will assist you in obtaining the Certificate of Creditable Coverage, if needed.

This Preexisting Condition waiting period does not apply to those persons who were members of the Health Care Plan and applied for coverage at the time that the Employer initially purchased this coverage.

TERMINATION OF COVERAGE

You will no longer be entitled to the benefits described in this benefit booklet if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the entire coverage of your Employer terminates.

Further, termination of the agreement between the Claim Administrator and the Employer automatically terminates your coverage as described in this benefit booklet. It is the responsibility of the Employer to notify you in the event the agreement is terminated with the Claim Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of termination of the Employer's agreement with the Claim Administrator.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under the Health Care Plan described in this benefit booklet except as otherwise specifically stated in the ''Extension of Benefits in Case of Termination'' provisions of this benefit booklet. However, termination of the Employer agreement with the Claim Administrator and/or termination of your coverage under the Health Care Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this benefit booklet, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible (for example, date of marriage, date of divorce, date the limiting age is reached).

Other options available for Continuation of Coverage are explained in the COBRA Section of this benefit booklet.

Upon termination of your coverage under the Health Care Plan, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your dependent's coverage under the Health Care Plan.

UTILIZATION REVIEW PROGRAM

The Claim Administrator has established the Utilization Review Program to assist you in determining the course of treatment that will maximize your benefits under this Health Care Plan. The Utilization Review Program requires a review of the following Covered Services **before** such services are rendered:

- Inpatient Hospital services
- Skilled Nursing Facility services
- Services received in a Coordinated Home Care Program
- Private Duty Nursing Services

Failure to contact the Claim Administrator as required or to comply with the determinations of the Claim Administrator will result in a reduction in benefits. The toll-free telephone number for medical pre-notification is on your Blue Cross and Blue Shield identification card. Please read the provisions below very carefully.

The provisions of this section do not apply to the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment. The treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to the provisions specified in THE CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT section of this benefit booklet.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

  Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the Hospital admission.

  If the proposed Hospital admission or health care services are determined to be not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised verbally of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. These letters may not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

  Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, con-

ditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

In the event of an emergency admission, in order to receive maximum benefits under this benefit booklet, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Pregnancy/Maternity Admission Review**

  Pregnancy/Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Health Care Plan.

  In the event of a maternity admission, in order to receive maximum benefits under this benefit booklet, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

  Even though you are not required to call the Claim Administrator prior to your maternity admission, if you call the medical pre-notification number as soon as you find out you are pregnant, the Claim Administrator will provide you information on support programs to assist you during pregnancy.

- **Skilled Nursing Facility Preadmission Review**

  Skilled Nursing Facility preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Coordinated Home Care Program Preadmission Review**

  Coordinated Home Care Program preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Private Duty Nursing Service Review**

  Private Duty Nursing Service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  Whenever Private Duty Nursing Service is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to receiving services.

CASE MANAGEMENT

Case management is a collaborative process that assists you with the coordination of complex care services. A Claim Administrator case manager is available to you as an advocate for cost-effective interventions.

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

Upon completion of the preadmission or emergency review, the Claim Administrator will send a letter to your Physician and/or the Hospital confirming that you or your representative called the Claim Administrator and that an approved length of service or length of stay was assigned.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Claim Administrator. Should the Claim Administrator provide notification of a decision to not authorize payment for Inpatient care or other health care services or supplies to you, your

Physician, and/or the Hospital or other Provider. The notification will specify the dates, services and/or supplies that are not in benefit. For further details regarding Medically Necessary care and other exclusions from coverage, see the EXCLUSIONS - WHAT IS NOT COVERED section in this benefit booklet.

The Claim Administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Claim Administrator's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is a Covered Service under the Health Care Plan.

In the event that the Claim Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that the Claim Administrator's Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as medically necessary, the Claim Administrator will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Health Care Plan.

NOTE: Keep in mind that a Medically Necessary determination does not guarantee that benefits are available. For example, it might be determined that a service is Medically Necessary, however, the Health Care Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the benefit provision in the benefit booklet.

UTILIZATION REVIEW PROCEDURE

The following information is required when you contact the Claim Administrator:

1. The name of the attending and/or admitting Physician;
2. The name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. The scheduled admission and/or service date; and
4. A preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, the Claim Administrator:

1. will review the information provided and seek additional information as necessary.
2. will issue a determination that the services are either Medically Necessary or are not Medically Necessary.
3. will provide notification of the determination.

APPEAL PROCEDURE

If you or your Physician disagree with the determination of the Claim Administrator prior to or while receiving services, you may appeal that decision. You should call the Claim Administrator's customer service number on your identification card. Your Physician should use the contact information in the notification letter.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Health Care Service Corporation
P. O. Box A3957
Chicago, Illinois 60601

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any relevant documents held by the Claim Administrator, if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Claim Administrator will not interfere with your relationship with any Provider. However, the Claim Administrator has established the Utilization Review Program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this benefit booklet.

Should you fail to notify the Claim Administrator as required in the Preadmission Review provision of this section, you will then be responsible for the first $200 of the Hospital or facility charges for an eligible stay or $200 of the charges for eligible Covered Services for Private Duty Nursing in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit

booklet. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet nor can it be applied to your out-of-pocket expense limit, if applicable, as described in this benefit booklet.

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Review Program do not apply to you if you are Medicare eligible and have secondary coverage provided under the Health Care Plan.

CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT

The Claim Administrator's Mental Health Unit has been established to perform preadmission review and length of stay review for your Inpatient Hospital services for the treatment of Mental Illness and Substance Abuse. The Mental Health Unit is staffed primarily by Physicians, Psychologists, and registered nurses.

Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit will result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

  Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  Whenever a nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Abuse is recommended by your Physician, you must, in order to receive maximum benefits described in this benefit booklet, call the Mental Health Unit. This call must be made at least one day prior to the Hospital admission.

  If the proposed Hospital admission does not meet the criteria for Medically Necessary care, it will be referred to a Physician in the Mental Health Unit. If the Mental Health Unit Physician concurs that the proposed admission does not meet the criteria for Medically Necessary care, some days or the entire hospitalization will be denied. Your Physician and the Hospital will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. The Mental Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission.

- **Emergency Mental Illness Admission Review**

  Emergency Mental Illness Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  In the event of an Emergency Mental Illness Admission, you or someone who calls on your behalf must, in order to receive maximum benefits under this benefit booklet, notify the Mental Health Unit no later than 48 hours or as soon as reasonably possible after the admission has occurred. If the

call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Partial Hospitalization Treatment Program Review**

  Partial Hospitalization Treatment Program review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  Whenever an admission to a Partial Hospitalization Treatment Program is recommended by your Physician, you must, in order to receive maximum benefits described in this benefit booklet, call the Mental Health Unit. This call must be made at least one day prior to the admission.

- **Length of Stay Review**

  Length of stay review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  Upon completion of the preadmission or emergency admission review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental Health Unit. A letter assigning a length of service or length of stay will be sent to your Physician and/or the Hospital.

  An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the Mental Health Unit. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Mental Health Unit Physician for review.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Mental Health Unit. Should the Mental Health Unit Physician concur that the Inpatient care or other health care services or supplies are not Medically Necessary, written notification of the decision will be provided to you, your Physician, and/or the Hospital or other Provider, and will specify the dates that are not in benefit. For further details regarding Medically Necessary care and other exclusions described in this benefit booklet, see the section entitled, ''EXCLUSIONS - WHAT IS NOT COVERED.''

The Mental Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Physician. The Mental Health Unit's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is Medically Necessary under the Health Care Plan.

In the event that the Mental Health Unit determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician decides they were not Medically Necessary.

MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit, you should be prepared to provide the following information:

1. the name of the attending and/or admitting Provider;
2. the name of the Hospital or facility where the admission and/or service has been scheduled;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Mental Health Unit, the Mental Health Unit:

1. will review the medical information provided and follow-up with the Provider;
2. may determine that the services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Physician disagree with the determinations of the Mental Health Unit prior to or while receiving services, you or the Provider may appeal that determination by contacting the Mental Health Unit and requesting an expedited appeal. The Mental Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Provider will be notified of the Mental Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Provider still disagree with the Mental Health Unit Physician, you may request an appeal in writing as outlined below.

Written Appeal

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter from the Mental Health Unit, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield Mental Health Unit
P. O. Box 805107
Chicago, Illinois 60680-4112

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any pertinent documents held by the Claim Administrator, if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Mental Health Unit will not interfere with your relationship with any Provider. However, the Mental Health Unit has been established for the specific purpose of assisting you in maximizing your benefits as described in this benefit booklet.

Should you fail to notify the Mental Health Unit as required in the Preadmission Review provision of this section, you will then be responsible for the first $200 of the Hospital charges for an eligible Hospital stay in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet nor can it be applied to your out-of-pocket expense limit, if applicable to this benefit booklet.

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM ("IBMP")

In addition to the benefits described in this benefit booklet, if your condition would otherwise require continued care in a Hospital or other health care facility, provision of alternative benefits for services rendered by a Participating Provider in accordance with an alternative treatment plan may be available to you.

Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of the Health Care Plan.

MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.

THE PARTICIPATING PROVIDER OPTION

Your Employer has chosen the Claim Administrator's "Participating Provider Option" for the administration of your Hospital and Physician benefits. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

As a participant in the Participating Provider Option a directory of Participating Providers is available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at *www.bcbsil.com* for a list of Participating Providers. While there may be changes in the directory from time to time, selection of Participating Providers by the Claim Administrator will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Employer annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Provider.

Before reading the description of your benefits, you should understand the terms "Benefit Period" and "Deductible" as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

Each benefit period you must satisfy a $350 deductible. In other words, after you have claims for more than $350 of Covered Services in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.

If you have any expenses for Covered Services during the last three months of a benefit period which were or could have been applied to that benefit period's program deductible, these expenses may be applied toward the program deductible of the next benefit period.

FAMILY DEDUCTIBLE

If you have Family Coverage and your family has reached the program deductible amount of $700, it will not be necessary for anyone else in your family to meet a program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members are required to meet a program deductible before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible.

In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one program deductible will be applied against those Covered Services.

The people who were Eligible Persons at the time the Health Care Plan became effective are entitled to a special credit toward your Participating Provider program deductible for the first benefit period. This special credit applies to eligible expenses incurred for Covered Services within the prior contract's benefit period, if not completed. Such expenses can be applied toward the Participating Provider program deductible for the first benefit period under this Health Care Plan. However, this is only true if your Health Care Plan had "major medical" type coverage immediately prior to purchasing this coverage.

HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your benefit booklet tells you what Hospital services are covered and how much will be paid for each of these services.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Your benefits are also subject to the Preexisting Condition waiting period. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

The level of benefits paid for Hospital Covered Services is generally greater when received in an Administrator Hospital or other Administrator facility.

Remember, whenever the term ''you'' or ''your'' is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

1. Bed, board and general nursing care when you are in:
   - — a semi-private room
   - — a private room
   - — an intensive care unit
2. Ancillary services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

Partial Hospitalization Treatment

Benefits are available for this program only if it is an Administrator Program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by the Claim Administrator.

Coordinated Home Care

Benefits will be provided for services under a Coordinated Home Care Program.

You are entitled to benefits for 40 visits in a Coordinated Home Care Program per benefit period.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Provider

When you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider, benefits will be provided at 80% of the Eligible Charge after you have met your program deductible, unless otherwise specified in this benefit booklet. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Participating Provider

When you receive Inpatient Covered Services from a Non-Participating Provider or in an Administrator Program of a Non-Participating Provider, benefits will be provided at 70% of the Eligible Charge, after you have met your program deductible. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Administrator Provider

When you receive Inpatient Covered Services from a Non-Administrator Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible.

Benefits for an Inpatient Hospital admission to a Non-Administrator or Non-Participating Provider resulting from Emergency Accident Care or Emergency Medical Care will be provided at the same payment level which you would have received had you been in a Participating Hospital for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by the Claim Administrator to be serious and therefore not permitting your safe transfer to a Participating Hospital or other Participating Provider.

Benefits for an Inpatient Hospital admission to a Non-Administrator or Non-Participating Hospital resulting from Emergency Accident Care or Emergency Medical Care will be provided at the Non-Participating Hospital payment level or the Non-Administrator Hospital payment level (depending on the type of Provider) for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by the Claim Administrator as not being serious and therefore permitting your safe transfer to a Participating Hospital or other Participating Provider.

In order for you to continue to receive benefits at the Participating Provider payment level following an emergency admission to a Non-Administrator or Non-Participating Hospital, you must transfer to a Participating Provider as soon as your condition is no longer serious.

OUTPATIENT HOSPITAL CARE

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Emergency Accident Care—treatment must occur within 72 hours of the accident or as soon as reasonably possible.
8. Emergency Medical Care
9. Mammograms —Benefits for routine mammograms will be provided at the benefit payment level described in the Wellness Care provision of this benefit booklet. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.
10. Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females at the benefit payment level described in the Wellness Care provision of this benefit booklet.
11. Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males at the benefit payment level described in the Wellness Care provision of this benefit booklet.
12. Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination. Benefits will be provided at the benefit payment level described in the Wellness Care provision of this benefit booklet.
13. Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

    Benefits for colorectal cancer screening will be provided at the benefit payment described in the Wellness Care provision of this benefit booklet.

Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedures will be provided at the benefit payment level for Surgery described in this benefit booklet.

14. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

Participating Provider

Benefits will be provided at 80% of the Eligible Charge after you have met your program deductible when you receive Outpatient Hospital Covered Services from a Participating Provider.

Benefits for Outpatient Diagnostic Service and mammograms will be provided at 100% of the Eligible Charge from a Participating Provider for the first $200 per benefit period. Your program deductible will not apply. Thereafter, benefits for Outpatient Diagnostic Service and mammograms will be provided at 80% of the Eligible Charge after you have met your program deductible.

Non-Participating Provider

When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at 70% of the Eligible Charge after you have met your program deductible.

Benefits for Outpatient Diagnostic Service and mammograms will be provided at 100% of the Eligible Charge from a Non-Participating Provider for the first $200 per benefit period. Your program deductible will not apply. Thereafter, benefits for Outpatient Diagnostic Service and mammograms will be provided at 70% of the Eligible Charge from a Non-Participating Provider after you have met your program deductible.

Non-Administrator Provider

When you receive Outpatient Hospital Covered Services from a Non-Administrator Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible. Covered Services received for Emergency Accident Care and Emergency Medical Care from a Non-Administrator Provider will be paid at the same payment level which would have been paid had such services been received from a Participating Provider.

Emergency Care

Benefits for Emergency Accident Care will be provided at 80% of the Eligible Charge when you receive Covered Services from a Participating Provider. Benefits for Emergency Accident Care will be provided at 70% of the Eligible Charge when you receive Covered Services from either a Non-Participating or Non-Administrator Provider.

Benefits for Emergency Accident Care will be subject to the program deductible.

Benefits for Emergency Medical Care will be provided at 80% of the Eligible Charge when you receive Covered Services from a Participating Provider. Benefits for Emergency Medical Care will be provided at 70% of the Eligible Charge when you receive Covered Services from either a Non-Participating or Non-Administrator Provider.

Benefits for Emergency Medical Care will be subject to the program deductible.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge whether or not you have met your program deductible.

WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER (HOSPITAL)

If you must receive Hospital Covered Services which the Claim Administrator has reasonably determined are unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.

PHYSICIAN BENEFIT SECTION

This section of your benefit booklet tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Your benefits are also subject to the Preexisting Condition waiting period. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available under this Benefit Section, services must be Medically Necessary and you must receive such services on or after your Coverage Date.

Remember, whenever the term ''you'' or ''your'' is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Health Care Plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

   In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic dis-

ability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
3. Sterilization Procedures (even if they are elective).

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Claim Charge and will not be subject to the program deductible. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

Medical Care

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Abuse Treatment Facility or
2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
3. you visit your Physician's office or your Physician comes to your home.

No benefits are available under this Benefit Section for the treatment of Mental Illness or Outpatient Substance Abuse Rehabilitation Treatment. In addition, the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to the maximums specified in the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.

Consultations

Your coverage includes benefits for consultations. The consultation must be requested by your Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who also renders Surgery or Maternity Service during the same admission.

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered

by a Physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Diagnostic Service—Benefits will be provided for those services related to covered Surgery or Medical Care.

Emergency Accident Care—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

Emergency Medical Care

Electroconvulsive Therapy

Allergy Injections and Allergy Testing

Chemotherapy

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Acupuncture

Chiropractic and Osteopathic Manipulation—Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures.

Radiation Therapy Treatments

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.

Mammograms —Benefits for routine mammograms will be provided at the benefit payment described in the Wellness Care provision of this benefit booklet. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.

Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females at the benefit payment level described in the Wellness Care provision of this benefit booklet.

Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males at the benefit payment level described in the Wellness Care provision of this benefit booklet.

Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination. Benefits for ovarian cancer screening will be provided at the benefit payment level described in the Wellness Care provision of this benefit booklet.

Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Durable Medical Equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Routine Vision Examination—Benefits will be provided for one routine vision examination(s), limited to a maximum of $50 per benefit period.

Leg, Back, Arm and Neck Braces

Prosthetic Appliances

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

1. they are required to replace all or part of an organ or tissue of the human body, or
2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

Benefits for colorectal cancer screening will be provided at the benefit payment level described in the Wellness Care provision of this benefit booklet. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedure will be provided at the benefit payment level for Surgery described in this benefit booklet.

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by the Claim Administrator and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at 80% of the Maximum Allowance after you have met your program deductible, unless otherwise specified in this benefit booklet. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this benefit booklet and may bill you for the difference between the Claim Administrator's benefit payment and the Provider's charge to you.

Benefits for Outpatient Diagnostic Service and mammograms will be provided at 100% of the Maximum Allowance from a Participating Provider for the first $200 per benefit period. Your program deductible will not apply. Thereafter, benefits

for Outpatient Diagnostic Service and mammograms will be provided at 80% of the Maximum Allowance from a Participating Provider after you have met your program deductible.

Non-Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided at 70% of the Maximum Allowance after you have met your program deductible.

Benefits for Outpatient Diagnostic Service and mammograms will be provided at 100% of the Maximum Allowance from a Non-Participating Provider for the first $200 per benefit period. Your program deductible will not apply. Thereafter, benefits for Outpatient Diagnostic Service and mammograms will be provided at 70% of the Maximum Allowance from a Non-Participating Provider after you have met your program deductible.

Emergency Care

Benefits for Emergency Accident Care will be provided at 80% of the Maximum Allowance when rendered by a Participating Provider after you have met your program deductible. Benefits for Emergency Accident Care will be provided at 70% of the Maximum Allowance when rendered by a Non-Participating Provider after you have met your program deductible.

Benefits for Emergency Medical Care will be provided at 80% of the Maximum Allowance when rendered by a Participating Provider after you have met your program deductible. Benefits for Emergency Medical Care will be provided at 70% of the Maximum Allowance when rendered by a Non-Participating Provider after you have met your program deductible.

However, Covered Services for Emergency Accident Care and Emergency Medical Care resulting from a criminal sexual assault or abuse will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers

- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists

- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Speech Therapists
- other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.

OTHER COVERED SERVICES

OTHER COVERED SERVICES

This section of your benefit booklet describes ''Other Covered Services'' and the benefits that will be provided for them.

- Blood and blood components
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Your benefits for Private Duty Nursing Service are limited to a maximum of $3,000 per month.
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints
- Naprapathic Service — Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of $1,000 per benefit period.
- Wigs—Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to Chemotherapy, radiation therapy or alopecia.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your program deductible, benefits will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance for any of the Covered Services described in this section.

When you receive Other Covered Services from a Participating or Non-Participating Provider, benefits for Other Covered Services will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Clinical Nurse Specialists

- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Speech Therapists
- other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.

SPECIAL CONDITIONS AND PAYMENTS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

— If both the donor and recipient have coverage each will have their benefits paid by their own program.

— If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this benefit booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.

— If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation and delivery of the donor organ.

— the removal of the organ from the donor.

— the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

— **Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled.**

— If you are the recipient of the transplant, benefits will be provided for transportation, lodging and meals for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this benefit booklet, benefits for transportation, lodging and meals will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

  • You and your companion are each entitled to benefits for lodging and meals up to a combined maximum of $200 per day.

- Benefits for transportation, lodging and meals are limited to a lifetime maximum of $10,000.

— In addition to the other exclusions of this benefit booklet, benefits will not be provided for the following:

  - Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
  - Travel time and related expenses required by a Provider.
  - Drugs which do not have approval of the Food and Drug Administration.
  - Storage fees.
  - Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization. Benefits will be limited to a maximum of 36 Outpatient treatment sessions within the six month period.

WELLNESS CARE

Benefits will be provided for Covered Services rendered to you, even though you are not ill. Benefits will be limited to the following services:

1. Immunizations;
2. Routine physical examinations;
3. Routine gynecological examinations – one per benefit period;
4. Routine diagnostic tests.

Participating Provider

When you receive Covered Services for wellness care from a Participating Provider, benefits will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to the program deductible.

Non-Participating Provider

When you receive Covered Services for wellness care from a Non-Participating Provider, benefits will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to the program deductible.

Wellness Care Benefit Maximum

Benefits for wellness care will be limited to a maximum of $500 per benefit period.

SKILLED NURSING FACILITY CARE

The following are Covered Services when you receive them in a Skilled Nursing Facility:

1. Bed, board and general nursing care.
2. Ancillary services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

Benefits for Covered Services rendered in an Administrator Skilled Nursing Facility will be provided at 80% of the Eligible Charge after you have met your program deductible.

Benefits for Covered Services rendered in a Non-Administrator Skilled Nursing Facility will be provided at 50% of the Eligible Charge, once you have met your program deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this benefit booklet are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by an Administrator Ambulatory Surgical Facility will be provided at 80% of the Eligible Charge. Benefits for services by a Non-Administrator Ambulatory Surgical Facility will be provided at 50% of the Eligible Charge.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible.

SUBSTANCE ABUSE REHABILITATION TREATMENT

Benefits for all of the Covered Services previously described in this benefit booklet are available for Substance Abuse Rehabilitation Treatment. In addition, benefits will be provided if these services are rendered by a Substance Abuse Treatment Facility. Benefits will be provided at the payment levels described later in this benefit booklet. Substance Abuse Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Administrator Provider facility payment level described later in this benefit section.

MENTAL ILLNESS SERVICES

Benefits for all of the Covered Services previously described in this benefit booklet are available for the diagnosis and/or treatment of a Mental Illness. Medical Care for the treatment of a Mental Illness is eligible when rendered by (1) a Physician; (2) a Psychologist, Clinical Social Worker or Clinical Professional Counselor; or (3) a Marriage and Family Therapist working within the scope of their license.

Benefit Payment for Outpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment

Benefits for Outpatient Mental Illness treatment will be provided at 80% of the Eligible Charge or at 80% of the Maximum Allowance when you receive services from a Participating Provider after you have met your program deductible. When you receive Covered Services from a Non-Participating Provider for Outpatient Mental Illness treatment, benefits will be provided at 70% of the Eligible Charge or 70% of the Maximum Allowance after you have met your program deductible.

Benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program approved by the Claim Administrator) will be provided at 80% of the Eligible Charge or at 80% of the Maximum Allowance when you receive services from a Participating Provider after you have met your program deductible.

When you receive Covered Services from a Non-Participating Provider for Outpatient Substance Abuse Rehabilitation Treatment, benefits will be provided at 70% of the Eligible Charge or 70% of the Maximum Allowance after you have met your program deductible.

Benefit Payment for Inpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment

Benefits for the Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

Lifetime Benefit Maximum for treatment of Mental Illness

You are entitled to a lifetime maximum of 40 Inpatient Hospital days for Inpatient treatment of Mental Illness.

You are entitled to a lifetime maximum of 225 Outpatient visits for Outpatient treatment of Mental Illness.

Lifetime Benefit Maximum for Substance Abuse Rehabilitation Treatment

A lifetime maximum of $27,500 will apply to benefits for Inpatient Substance Abuse Rehabilitation Treatment.

A lifetime maximum of $22,500 will apply to benefits for Outpatient Substance Abuse Rehabilitation Treatment.

None of the charges for the Inpatient and/or Outpatient treatment of Mental Illness or Substance Abuse Rehabilitation Treatment will be included in the calculation of your out-of-pocket expenses.

MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth.)

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours).

Your coverage also includes benefits for elective abortions if legal where performed.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all of the Covered Services previously described in this benefit booklet are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are not limited to:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge; and
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.

PAYMENT PROVISIONS

Lifetime Maximum

The total maximum amount of benefits to which you are entitled under this Participating Provider Option program is $5,000,000. This is an individual maximum. There is no family maximum.

As you use your benefits, a certain amount will automatically be restored to your lifetime maximum each year. This amount will be $1,000 or the amount you have received in benefits that benefit period, whichever is less.

Cumulative Benefit Maximums

All benefits payable under this benefit booklet are cumulative. Therefore, in calculating the benefit maximums payable for a particular Covered Service or in calculating the remaining balance under the Lifetime Maximums, the Claim Administrator will include benefit payments under both this and/or any prior or subsequent Claim Administrator's benefit booklet issued to you as an Eligible Person or a dependent of an Eligible Person under this plan.

OUT-OF-POCKET EXPENSE LIMIT

If you have Individual Coverage and your out-of-pocket expenses during one benefit period (the amount remaining unpaid for Covered Services after benefits have been provided) equals $1,000, any additional eligible Claims (except for those charges specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for Covered Services which you are responsible after benefits have been provided.

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- the program deductible(s)
- charges that exceed the Eligible Charge or Maximum Allowance
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this benefit booklet
- charges for Covered Services received for the treatment of Mental Illness and/or Substance Abuse Rehabilitation Treatment
- Copayments resulting from noncompliance with the provisions of the Utilization Review Program and/or the Claim Administrator's Mental Health Unit
- and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.

If you have Family Coverage and your family's out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $2,000 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those charges specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this plan is terminated, benefits will be provided for, and limited to, the Covered Services of this plan which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

SUPPLEMENTAL ACCIDENT CARE BENEFIT SECTION

In the other Benefit Sections of this benefit booklet, your benefits for Emergency Accident Care were explained. In addition to those benefits, your coverage also provides you with benefits for certain other services that you might receive as the result of an accident. These additional benefits are called Supplemental Accident Care Benefits and this section describes the Supplemental Accident Care Covered Services and the benefits that are available for them.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For Supplemental Accident Care benefits to be available, the services must be Medically Necessary.

These Supplemental Accident Care benefits will not duplicate the coverage that you are entitled to under the Hospital and Physician Benefit Sections. Rather, these benefits will supplement that coverage. In other words, your benefits for Supplemental Accident Care will not begin until you have received benefits for the initial Outpatient visit of Emergency Accident Care.

COVERED SERVICES

Your Supplemental Accident Care coverage will provide benefits for the following Covered Services as long as you receive these services within 90 days of the date of the accident and the services are received as a result of the accident.

1. Inpatient and Outpatient care in a Hospital.
2. Medical and surgical treatment by a Physician, Podiatrist or Chiropractor.
3. Diagnostic Services.
4. Private Duty Nursing Service.

Benefit Payment for Supplemental Accident Care

Benefits will be provided at 100% of the Eligible Charge or Usual and Customary Fee for Supplemental Accident Care Covered Services, up to a maximum of $500 per accident (but only to the extent such Covered Services are not covered under the other Benefit Sections of this benefit booklet).

HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician; and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services – Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are **not** covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including but not limited, to Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this benefit booklet.

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same level as described for Inpatient Hospital Covered Services.

BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS

This section describes the benefits which will be provided for Medicare Eligible Covered Persons who are not affected by MSP laws, unless otherwise specified in this benefit booklet (see provisions entitled ''Medicare Eligible Covered Persons'' in the ELIGIBILITY SECTION of this benefit booklet).

The benefits and provisions described throughout this benefit booklet apply to you, however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Health Care Plan is as follows:

1. determine what the payment for a Covered Service would be following the payment provisions of this coverage and
2. deduct from this resulting amount the amount paid or payable by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.) The difference, if any, is the amount that will be paid under the Health Care Plan.

When you have a Claim, you must send the Claim Administrator a copy of your Explanation of Medicare Benefits ("EOMB") in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

EXCLUSIONS—WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— **Hospitalization, services and supplies which are not Medically Necessary.**

No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- — Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- — Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- — Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- — Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- — Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- — The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and

therefore not eligible for payment under the terms of your Health Care Plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against the Claim Administrator, either at law or in equity. To initiate your appeal, you must give the Claim Administrator written notice of your intention to do so within 180 days after you have been notified that your Claim has been denied by writing to:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690

You may furnish or submit any additional documentation which you or your Physician believe appropriate.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

— Services or supplies that are not specifically mentioned in this benefit booklet.

— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance

benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

— Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

— Services or supplies that do not meet accepted standards of medical and/or dental practice.

— Investigational Services and Supplies and all related services and supplies, other than the cost of routine patient care associated with Investigational cancer treatment, if those services or supplies would otherwise be covered under the benefit booklet if not provided in connection with an approved clinical trial program.

— Custodial Care Service.

— Long Term Care Service.

— Respite Care Service, except as specifically mentioned under the Hospice Program.

— Inpatient Private Duty Nursing Service.

— Routine physical examinations, unless otherwise specified in this benefit booklet.

— Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness.

— Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.

— Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

— Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

— Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this benefit booklet.

— Blood derivatives which are not classified as drugs in the official formularies.

— Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the

refractive state of the eye, except as specifically mentioned in this benefit booklet.

— Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

— Routine foot care, except for persons diagnosed with diabetes.

— Immunizations, unless otherwise specified in this benefit booklet.

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy.

— Maintenance Care.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation.

— Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this benefit booklet.

— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Health Care Plan.

— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.

— Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

— Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this benefit booklet.

— Services and supplies rendered or provided for the diagnosis and treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injections, fertility and other drugs, Surgery, artificial insemination and all forms of in-vitro fertilization.

— Outpatient prescription drugs or medicines except for immunosuppressive drugs prescribed in connection with a human organ transplant.

— Surgery for morbid obesity (including, but not limited to, bariatric Surgery).

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to insure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.
2. When a dependent child receives services, the coverage under which the father is the Eligible Person is primary.
   - — However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;
   - — when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

     Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Claim Administrator, and upon its request to provide a copy, of such court decree.
3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

— pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.

— recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.

CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA)

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

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

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

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

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

When Is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18–month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

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

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under

the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

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

Keep Your Plan Informed Of Address Changes

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

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

HOW TO FILE A CLAIM

In order to obtain your benefits under this Health Care Plan, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your ID card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember however, it is your responsibility to insure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how much was paid. In some cases the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

   Blue Cross and Blue Shield of Illinois
   P. O. Box 805107
   Chicago, Illinois 60680-4112

In any case, Claims should be filed with the Claim Administrator on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

The Claim Administrator will pay all Claims within 30 days of receipt of all information required to process a Claim. In the event that the Claim Administrator does not process a Claim within this 30–day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Claim Administrator will notify you or the valid assignee when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assign-

ment of Benefits" provisions in the GENERAL PROVISIONS section of this benefit booklet.)

If the Claim is denied in whole or in part, you will receive a notice from the Claim Administrator with: (1) the reasons for denial; (2) a reference to the health care plan provisions on which the denial is based; (3) a description of additional information which may be necessary to perfect the appeal, and (4) an explanation of how you may have the Claim reviewed by the Claim Administrator if you do not agree with the denial.

CLAIM REVIEW PROCEDURES

If your Claim has been denied in whole or in part, you may have your Claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure.

Within 180 days after you receive notice of a denial or partial denial, write to the Claim Administrator. The Claim Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690

You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

While the Claim Administrator will honor telephone requests for information, such inquiries will not constitute a request for review.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. The Claim Administrator will give you a written decision within 60 days after it receives your request for review.

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters. The Claim Administrator offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers (''Administrator Providers'') in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how the Claim Administrator's separate financial arrangements with Providers work, please consider the following example:

a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is $1,000. How is the $1,000 bill paid?

b. You personally will have to pay the deductible and Coinsurance amounts set out in your benefit booklet.

c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.

e. After taking into account the deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your deductible has already been satisfied, and your Coinsurance is $140, then the Claim Administrator has to satisfy the rest of the Hospital bill, or $860. Assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator will usually be able to satisfy the $860 bill that remains after your Coinsurance and deductible, by paying less than $860 to the Hospital, often substantially less than $860. The Claim Administrator receives, and keeps for its own account, the difference between the $860 bill and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor your Employer are entitled to any part of these savings.

Other Blue Cross and Blue Shields' Separate Financial Arrangements with Providers

Blue Card

The Claim Administrator hereby informs you that other Blue Cross and Blue Shield Plans outside of Illinois ("Host Blue") may have contracts similar to the contracts described above with certain Providers ("Host Blue Providers") in their service area.

When you receive health care services through BlueCard outside of Illinois and from a Provider which does not have a contract with the Claim Administrator, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to the Claim Administrator.

a. Suppose you receive covered medical services for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by the Claim Administrator.

b. The provider has negotiated with the Host Blue a price of $80, even though the provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the covered service is $80. The Claim Administrator would then base the amount you must pay for the service – the amount applied to your deductible, if any, and your coinsurance percentage – on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this benefit booklet.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increases or reductions to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, the Claim Administrator would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Blue Cross and Blue Shields' Separate Financial Arrangements with Prescription Drug Providers

The Claim Administrator hereby informs you that it has contracts, either directly or indirectly, with Prescription Drug Providers ("Participating Prescription Drug Providers") to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under this Health Care Plan. Under its contracts with Participating Prescription Drug Providers, the Claim Administrator may receive from these Providers discounts for prescription drugs dispensed to you.

The Claim Administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Claim Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.

b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.

c. A Covered Person's claim for benefits under this Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Health Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS

a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.

b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.

c. The use of an adjective such as Participating, Administrator or approved in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Participating, Administrator, approved or any similar modifier or the use of a term such as Non-Administrator or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

d. Each Provider provides Covered Services only to you and does not deal with or provide any services to your Employer (other than as an individual Covered Person) or your Employer's ERISA Health Benefit Program.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator's records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

5. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Health Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Health Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs

or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the Claim Administrator and/or your Employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator be able to make Claim Payments in accordance with MSP laws.

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

a. the Claim Administrator has the rights to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.

b. the Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklets regarding "Claim Administrator's Separate Financial Arrangements with Providers.")

RIDER TO THE BENEFIT BOOKLET FOR DISABLED OR RETIRED PUBLIC EMPLOYEES

The benefit booklet to which this Rider is attached and becomes a part, is hereby amended as follows:

If you are a public employee and are eligible for continued coverage for accident and health insurance under Sections 367g, 367h and 367j of the Illinois Insurance Code, you may establish and maintain such continued health coverage under this Health Care Plan, if you meet the following conditions:

1. You and your eligible dependents, must have been covered under this Health Care Plan on the day immediately preceding the effective date of eligibility for continued health coverage.
2. Once properly established, continued health coverage under this Health Care Plan may be maintained by you or your surviving spouse, until the loss of eligibility as specified in Sections 367g, 367h and 367j of the Insurance Code. It shall be your responsibility to inform the Claim Administrator of the loss of eligibility.
3. The election by you or your surviving spouse, to obtain a conversion plan as described in the conversion provisions of this Health Care Plan shall terminate any right to continue health coverage according to Sections 367g, 367h and 367j of the Insurance Code. No reinstatement of continued health coverage shall be permitted after such conversion has been effected or if the continued health coverage provided by this Rider has been terminated for any reason.
4. If you or your surviving spouse is continuing coverage under this Health Care Plan and becomes eligible for Medicare, the benefits under this Health Care Plan shall be reduced in accordance with the benefit provisions for Medicare Eligibles stated in this benefit booklet.
5. If a timely and valid election of continued health coverage has been made, you must remit the total monthly premium payment required to establish and maintain such coverage, whether such total monthly premium is contributed by you, deducted from a pension payment or paid directly to your Employer by you.

Except as amended by this Rider, all terms and conditions of the benefit booklet to which the Rider is attached will remain in full force and effect.

ASO-1

Effective Date: January 1, 2009

BENEFIT BOOKLET RIDER
(For Participating Provider Option Plans)

The benefit booklet, to which this Rider is attached and becomes a part, is amended as stated below.

A. DEFINITIONS SECTION

1. The following definition is added to the Definitions Section of your benefit booklet:

   RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.

   A "Participating Retail Health Clinic" means a Retail Health Clinic which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

   A "Non-Participating Retail Health Clinic" means a Retail Health Clinic which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

B. PHYSICIAN BENEFIT SECTION

1. The following Covered Services are added to the Physician Benefit Section of your benefit booklet:

   Amino Acid-Based Elemental Formulas—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is medically necessary. If you purchase the formula at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet.

   Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician. Benefits for clinical breast examinations will be provided at the benefit payment level described in the Wellness Care provision of this benefit booklet.

   Human Papillomavirus Vaccine—Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration. Benefits will be provided at the benefit payment level for immunizations described in the Wellness Care provision of this benefit booklet. If you purchase the vaccine at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered

Services described in the OTHER COVERED SERVICES section of this benefit booklet.

2. The following Providers are added to the list of Participating Providers in the Physician Benefit Section of your benefit booklet:
   - Retail Health Clinics
3. The following Providers are added to the list of Non-Participating Providers in the Physician Benefit Section of your benefit booklet:
   - Retail Health Clinics

C. OTHER COVERED SERVICES

1. The following Providers are added to the list of Participating Providers in the Other Covered Services section of your benefit booklet:
   - Retail Health Clinics
2. The following Providers are added to the list of Non-Participating Providers in the Other Covered Services section of your benefit booklet:
   - Retail Health Clinics

D. SPECIAL CONDITIONS AND PAYMENTS

The Wellness Care Benefit Maximum provision is replaced with the following:

Wellness Care Benefit Maximum

Benefits for wellness care will be limited to a maximum of $500 per benefit period.

The following Covered Services are not subject to the wellness care benefit maximum: routine mammogram, Pap smear test, prostate test and digital rectal examination, colorectal cancer screening, ovarian cancer screening, clinical breast examination and human papillomavirus vaccine.

E. EXCLUSIONS—WHAT IS NOT COVERED

The Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy exclusion is replaced with the following:

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this benefit booklet.

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the benefit booklet to which this Rider is attached will remain in full force and effect.

BENEFIT BOOKLET RIDER
REGARDING DEPENDENT LIMITING AGE

The benefit booklet, to which this Rider is attached and becomes a part, is amended as stated below.

ELIGIBILITY SECTION

The dependent limiting age provision under the **FAMILY COVERAGE** provision is revised to read as follows:

If you have Family Coverage, your expenses for Covered Services and those of your enrolled spouse and your (or your spouse's) enrolled unmarried children who are under age 26 will be covered.

Enrolled unmarried children will be covered up to age 30 if they:

- Live within the state of Illinois; and
- Have served as an active or reserve member of any branch of the Armed Forces of the United States; and
- Have received a release or discharge other than a dishonorable discharge.

Coverage for unmarried children will end on the limiting age birthday.

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the benefit booklet to which this Rider is attached will remain in full force and effect.

Your Health Care Benefit Program

HMO ILLINOIS
A Blue Cross HMO

a product of

Blue Cross and Blue Shield of Illinois

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

HMO GROUP CERTIFICATE RIDER

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

This Rider is attached to and becomes a part of your Certificate. The Certificate and any Riders thereto are amended as stated below.

A. EFFECTIVE DATE

The effective date of this Rider is the first Group effective date after September 23, 2010.

B. DEPENDENT COVERAGE

Benefits will be provided under this Certificate for your and/or your spouse's enrolled child(ren) up to the age of 26.

"Child(ren)" used hereafter, means a natural child(ren), a stepchild(ren), a child(ren) who is in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, child(ren) for whom you are the legal guardian under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status (if applicable under your Certificate), marital status, eligibility for other coverage or any combination of those factors. If the covered child(ren) is eligible military personnel, the limiting age is 30 years of age as described under the **FAMILY COVERAGE** provision in the ELIGIBILITY section of this Certificate.

C. INTERNAL AND EXTERNAL REVIEW INFORMATION AND PROCEDURES

The Clinical Appeals provision under the **HOW TO FILE A CLAIM** section is hereby revised to read as follows:

CLINICAL APPEALS

Upon receipt of a non-urgent pre-service or post-service Clinical Appeal, the Plan will notify the party filing the appeal within three business days if additional information is needed to review the appeal. Additional information must be submitted within five calendar days of request. The Plan shall render a determination on the appeal within 15 business days after it receives the requested information but in no event more than 30 days after the appeal has been received by the Plan.

NOTIFICATION

The third bullet in the **NOTIFICATION** section which appears directly above the **EXPEDITED EXTERNAL INDEPENDENT REVIEW** section is revised to read as follows:

- Procedures for requesting an external independent review, if your appeal is denied.

The following is hereby added to this Certificate:

INDEPENDENT EXTERNAL REVIEW

An **"Adverse Determination"** means a determination by the Plan or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness and the requested service or payment for the service is therefore denied, reduced or terminated.

A **"Final Adverse Determination"** means an adverse determination involving a covered benefit that has been upheld by the Plan or its designated utilization review organization, at the completion of the Plan's internal grievance process procedures as set forth by the Managed Care Reform and Patient Rights Act.

EXPEDITED INDEPENDENT EXTERNAL REVIEW

If you have a medical condition where the timeframe for completion of a) an expedited internal review of a grievance involving an Adverse Determination; b) a Final Adverse Determination as set forth in the Managed Care Reform and Patient Rights Act; or, c) a standard external review as set forth in the Managed Care Reform and Patient Rights Act, would seriously jeopardize your life or health or your ability to regain maximum function, then you have the right to have the Adverse Determination or Final Adverse Determination reviewed by an independent review organization not associated with the Plan. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility, then you may request an expedited independent external review.

You may also request an expedited external review if the treatment or service in question has been denied on the basis that it is considered experimental or investigational and your health care provider certifies in writing that the treatment or service would be significantly less effective if not started promptly.

Your request for an expedited independent external review may be submitted orally or in writing. Upon receipt of your request, an independent review or-

ganization registered with the Illinois Department of Insurance will be assigned to review the Plan's decision.

Within two business days after the date of receipt of all necessary information, the expedited independent external reviewer will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and you will receive notification from the Plan. The decision of the external independent reviewer is final. Until July 1, 2013, if you disagree with the determination of the external independent reviewer, you may contact the Illinois Department of Insurance.

STANDARD EXTERNAL INDEPENDENT REVIEW

You must submit a written request for an external independent review within four months of receiving an Adverse Determination or a Final Adverse Determination of a Clinical Appeal. You may submit additional information or documentation to support your request for the health care services.

Within five business days of receipt of your request, the Plan will complete a preliminary review to determine whether:

- you or your dependent was a covered person at the time the health care services were requested or provided;
- the service that is the subject of the Adverse Determination or the Final Adverse Determination was a Covered Service under this Certificate but the Plan has determined that the health care service does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;
- you have exhausted the Plan's internal grievance process; and
- you have provided all the information and forms required to process an external review.

For appeals relating to a determination based on treatment being experimental or investigational, the Plan will complete a preliminary review to determine whether the requested service or treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Service under this Certificate, except for the Plan's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under this Certificate. In addition, the licensed Physician who ordered or provided the services in question has certified that one of the following situations is applicable:

- standard health care services or treatments have not been effective in improving the condition of the covered person;
- standard health care services or treatments are not medically appropriate for the covered person;

- there is no available standard health care services or treatment covered by the Plan that is more beneficial than the recommended or requested service or treatment;
- the health care service or treatment is likely to be more beneficial to the covered person, in the opinion of the health care provider, than any available standard health care services or treatments; or
- that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to the covered person than any available standard health care services or treatments.

Within one business day after completion of the preliminary review, the Plan shall notify you in writing whether the request is complete and is eligible for an external review. If the request is not complete or not eligible for an external review, you shall be notified by the Plan in writing of what materials are required or the reason for ineligibility.

Within five business days of determining that a request is eligible for an external review, the Plan shall a) assign an independent review organization from the list of approved independent review organizations; and b) notify you of the request's eligibility and acceptance for an external review and the name of the independent review organization.

Within five business days upon the assignment of an external independent review organization, the Plan or it's designated utilization review organization, shall provide to the external independent reviewer the documents and any information considered in making the Adverse Determination or Final Adverse Determination.

Within five business days after the date of receipt of all necessary information, the external independent reviewer will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and you will receive notification from the Plan. The decision of the external independent reviewer is final. Until July 1, 2013, if you disagree with the determination of the external independent reviewer, you may appeal the decision of the external independent review organization to the Illinois Department of Insurance at (877) 527-9431.

Benefits will not be provided for services or supplies not covered under this Certificate even if the external independent reviewer determines that the health care services being appealed were medically appropriate.

D. GRANDFATHERED HEALTH PLAN DISCLOSURE REQUIREMENT

This group health plan believes this plan is a "grandfathered health plan" under 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 your Certificate 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 dollar limits on benefits for any individual.

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. You may also contact the Illinois Department of Insurance at (877) 527-9431 or http://insurance.illinois.gov.

If your health plan is subject to the Employee Retirement Income Security Act (ERISA), you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. For non-federal governmental plans, inquiries may be directed to the U.S. Department of Health and Human Services at www.healthreform.gov.

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the Certificate to which this Rider is attached will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Deborah Dorman-Rodriguez
Secretary

Patricia A. Hemingway Hall
President

RIDER FOR LIMITING AGE FOR DEPENDENT CHILDREN

The Certificate, to which this Rider is attached and becomes a part, is amended as stated below.

ELIGIBILITY

The third paragraph under the **Family Coverage** provision in the ELIGIBILITY section of this Certificate is amended to read as follows:

Coverage for unmarried children will end on the last day of the calendar month in which the limiting age birthday falls.

Except as amended by this Rider, all terms and conditions of the Certificate to which this Rider is attached will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Deborah Dorman-Rodriguez
Secretary

Patricia A. Hemingway Hall
President

A message from

BLUE CROSS AND BLUE SHIELD

Your Group has entered into an agreement with us (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association) to provide you with this HMO Illinois health care benefit program. In this Certificate, we refer to our company as the "Plan" and we refer to your employer, association or trust as the "Group".

YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER IS AN INDEPENDENT CONTRACTOR, NOT AN EMPLOYEE OR AGENT OF YOUR BLUE CROSS HMO. YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER RENDERS AND COORDINATES YOUR MEDICAL CARE. YOUR BLUE CROSS HMO IS YOUR BENEFIT PROGRAM, NOT YOUR HEALTH CARE PROVIDER.

We suggest that you read this entire Certificate very carefully. We hope that any questions that you might have about your coverage will be answered here.

THIS CERTIFICATE REPLACES ANY PREVIOUS CERTIFICATES THAT YOU MAY HAVE BEEN ISSUED BY THE PLAN.

If you have any questions once you have read this Certificate, talk to your Group Administrator or call us at your local Blue Cross and Blue Shield office. It is important to all of us that you understand the protection this coverage gives you.

Welcome to Blue Cross and Blue Shield! We are very happy to have you as a member and pledge you our best service.

Sincerely,

Patricia A. Hemingway Hall

Patricia A. Hemingway Hall
President and CEO

Deborah Dorman-Rodriguez

Deborah Dorman-Rodriguez
Secretary

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BENEFIT HIGHLIGHTS

Your health care benefits are highlighted below. However, it is necessary to read this entire Certificate to obtain a complete description of your benefits. It is important to remember that benefits will only be provided for services or supplies that have been ordered by your Primary Care Physician (PCP) or Woman's Principal Health Care Provider (WPHCP), unless specified otherwise in this Certificate.

PHYSICIAN BENEFITS

— Your Cost for Covered Services (unless specified otherwise below)	None
— Your Cost for Outpatient Office Visits	$20 per Visit
— Your Cost for Outpatient Specialist Physician Visits	$20 per Visit
— Your Cost for Outpatient Office Visits for Periodic Health Examinations or Routine Pediatric Care	$20 per Visit
— Your Cost for Outpatient Office Visits for the Treatment of Mental Illness Other Than Serious Mental Illness, when not authorized by your PCP or WPHCP	50% of Covered Services
— Limit on Number of Outpatient Rehabilitative Therapy Treatments	60 Treatments per Calendar Year

HOSPITAL BENEFITS

— Your Cost for Inpatient Covered Services	None
— Your Cost for the Inpatient Treatment of Mental Illness Other Than Serious Mental Illness, when not authorized by your PCP or WPHCP	50% of Covered Services
— Your Cost for Outpatient Covered Services	None

SUPPLEMENTAL BENEFITS

— Your Cost for Covered Services	None

EMERGENCY CARE BENEFITS

— Your Cost for an In-Area Emergency	$75 Emergency Room Copayment (waived if admitted to Hospital as an Inpatient immediately following emergency treatment)
— Your Cost for an Out-of-Area Emergency	$75 Emergency Room Copayment (waived if admitted to Hospital as an Inpatient immediately following emergency treatment)
— Your Cost for Emergency Ambulance Transportation	None

CHEMICAL DEPENDENCY TREATMENT BENEFITS

— Your Cost for Inpatient Chemical Dependency Treatment	None
— Your Cost for Outpatient Office Visits for Chemical Dependency Treatment	$20 per Visit
— Your Cost for Outpatient Specialist Physician Visits for Chemical Dependency Treatment	$20 per Visit

Refer to the OTHER THINGS YOU SHOULD KNOW section of your Certificate for information regarding Covered Services Expense Limitation

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS

— Your Cost for Prescription Drugs Obtained from a Prescription Drug Provider Participating in the **34-Day Supply** Prescription Drug Program:

— Generic Drugs, Insulin and Insulin Syringes	$10 per Prescription
— Formulary Brand-name Drugs	$20 per Prescription
— Non-Formulary Brand-name Drugs	$35 per Prescription
— Self-Injectable Drugs other than Insulin and Infertility Drugs	$50 per Prescription
— Diabetic Supplies	None

— Your Cost for Prescription Drugs Obtained from a Prescription Drug Provider Not Participating in the **34-Day Supply** Prescription Drug Program:

  — For drugs purchased within Illinois:
  No benefits will be provided for drugs purchased from a Non-Participating Prescription Drug Provider.

  — For drugs purchased outside Illinois:
  The appropriate Copayment(s) indicated above plus any difference between the Participating Provider's Charge and the Non-Participating Provider's Charge for drugs prescribed for emergency conditions.

— Your Cost for Prescription Drugs Obtained from a Prescription Drug Provider Participating in the **90-Day Supply** Prescription Drug Program:

— Generic Drugs, Insulin and Insulin Syringes	$20 per Prescription
— Formulary Brand-name Drugs	$40 per Prescription
— Non-Formulary Brand-name Drugs	$70 per Prescription
— Self-Injectable Drugs other than Insulin and Infertility Drugs	$50 per Prescription
— Diabetic Supplies	None

— Your Cost for Prescription Drugs Obtained from a Prescription Drug Provider Not Participating in the **90-Day Supply** Prescription Drug Program:

  — No benefits will be provided for a Prescription Drug Provider not participating in the 90-day supply program.

LIMITING AGE FOR DEPENDENT CHILDREN	26

ELIGIBILITY

The benefits described in this Certificate will be provided to persons who:

— Meet the definition of an Eligible Person as specified in the Group Policy;
— Have applied for this coverage;
— Have received a Blue Cross and Blue Shield identification card;
— Live within the Plan's service area. (Contact your Group or Member Services at 1-800-892-2803 for information regarding service area.); and,
— If Medicare eligible, have both Part A and B coverage.

REPLACEMENT OF DISCONTINUED GROUP COVERAGE

When your Group initially purchases this coverage, if such coverage is purchased as replacement of coverage under another carrier's group policy, persons who are Totally Disabled on the effective date of this coverage but who otherwise meet the definition of an Eligible Person under this coverage and who were covered under the prior group policy will be eligible for coverage under this Certificate.

Totally Disabled dependents of an Eligible Person will be considered eligible dependents under this Certificate provided such dependents meet the description of an eligible family member as specified below under the heading Family Coverage. Dependent children who have reached the limiting age of this Certificate will be considered eligible dependents under this Certificate if they were covered under the prior group policy and, because of a handicapped condition, are incapable of self sustaining employment and are dependent upon the Eligible Person or other care providers for lifetime care and supervision.

Such Totally Disabled persons will be entitled to all of the benefits of this Certificate. Benefits will be coordinated with benefits under the prior group policy and the prior group policy will be considered the primary coverage for all services rendered in connection with the disability when no coverage is available under this Certificate due to the absence of coverage in this Certificate. The provisions of this Certificate regarding Primary Care Physician referral remain in effect for such Totally Disabled persons.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own health care expenses are covered, not the health care expenses of other members of your family.

FAMILY COVERAGE

Under Family Coverage, your health care expenses and those of your enrolled spouse and your (and/or your spouse's) unmarried children who are under the limiting age specified in the BENEFIT HIGHLIGHTS section will be covered.

In addition, enrolled unmarried children will be covered up to the age of 30 if they:

- Live within the Plan's service area; and
- Have served as an active or reserve member of any branch of the Armed Forces of the United States; and

- Have received a release or discharge other than a dishonorable discharge.

Coverage for unmarried children will end on the last day of the period for which premium has been accepted.

If you have Family Coverage, newborn children will be covered from the moment of birth as long as the Plan receives notice of the birth within 31 days of the birth. Your Group Administrator can tell you how to submit the proper notice.

Children who are under your legal guardianship or who are in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, will be covered. In addition, if you have children for whom you are required by court order to provide health care coverage, those children will be covered.

Any children who are incapable of self-sustaining employment and are dependent upon you or other care providers for lifetime care and supervision because of a handicapped condition occurring prior to reaching the limiting age will be covered regardless of age as long as they were covered prior to reaching the limiting age specified in the BENEFIT HIGHLIGHTS section.

This coverage does not include benefits for foster children or grandchildren (unless such children have been legally adopted or are under your legal guardianship).

MEDICARE ELIGIBLE COVERED PERSONS

A series of federal laws collectively referred to as the ''Medicare Secondary Payer'' (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan ("GHP") coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

1. GHPs that cover individuals with end-stage renal disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has "current employment status."

2. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).

3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status." If the GHP is

a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

Please see your employer or Group Administrator if you have any questions regarding the ESRD Primary Period or any other provisions of the MSP laws and their application to you, your spouse or your dependents.

Your MSP Responsibilities

In order to assist your employer in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Plan and/or your employer regarding the Medicare eligibility of you, your spouse and covered dependent children. In addition, if you, your spouse or covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your employer or your group administrator promptly to ensure that your claims are processed in accordance with applicable MSP laws.

YOUR IDENTIFICATION CARD

You will receive an identification (ID) card from the Plan. Your ID card contains your identification number, the name of the Participating IPA/Participating Medical Group that you have selected and the phone number to call in an emergency. Always carry your ID card with you.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO YOUR FAMILY COVERAGE

You can change from Individual to Family Coverage or add dependents to your Family Coverage because of any of the following events:

- Marriage.
- Birth, adoption or placement for adoption of a child.
- Obtaining legal guardianship of a child.
- Loss of eligibility for other health coverage for you or your dependent if:
    a. The other coverage was in effect when you were first eligible to enroll for this coverage;
    b. The other coverage is not terminating for cause (such as failure to pay premiums or mailing a fraudulent claim); and
    c. Where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment in this coverage.

  This includes, but is not limited to, loss of coverage due to:
    a. Legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, or reduction in number of hours of employment;

b. In the case of HMO, coverage is no longer provided because an individual no longer resides in the service area or the HMO no longer offers coverage in the HMO service area in which the individual resides;

c. Reaching a lifetime limit on all benefits in another group health plan;

d. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent;

e. When Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss eligibility; or

f. When you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

— Termination of employer contributions towards your or your dependent's other coverage.

— Exhaustion of COBRA continuation coverage or state continuation coverage.

WHEN COVERAGE BEGINS

Your Family Coverage or the coverage for your additional dependent(s) will be effective from the date of the event if you apply for this change within 31 days of any of the following events:

— Marriage.

— Birth, adoption or placement for adoption of a child.

— Obtaining legal guardianship of a child.

— Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.

— Termination of employer contributions towards your or your dependent's other coverage.

— Exhaustion of COBRA continuation or state continuation coverage.

If coverage is lost in another group health plan because a lifetime limit on all benefits is reached under that coverage and you apply for Family Coverage or to add dependents within 31 days after a claim is denied due to reaching the lifetime limit, your Family Coverage or the coverage for your additional dependents will be effective from the date your claim was denied.

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 60 days of any of the following events:

— Loss of eligibility for you or your dependents when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or

— You or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You can get the application form from your Group Administrator. However, an application to add a newborn to Family Coverage is not necessary if an additional premium is not required. Please notify your Group Administrator so that your membership records can be adjusted.

LATE APPLICANTS

If you do not apply for Family Coverage or to add dependents within the allotted time, you will have to wait until your Group's annual open enrollment period to do so. Your Family Coverage or the coverage for your additional dependents will then be effective on the first day of the month following the open enrollment period. Benefits will not be provided for any treatment of an illness or injury to a newborn child unless you have Family Coverage. (Remember, you must add the newborn child within 31 days of the date of birth.)

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

You can apply to change from Family to Individual Coverage at any time. Your Group Administrator will give you the application and tell you the date that the change will be effective. Premiums will be adjusted accordingly.

TERMINATION OF COVERAGE

You will no longer be entitled to the health care benefits described in this Certificate when:

— You no longer meet the previously stated description of an Eligible Person; or

— The entire coverage of your Group terminates.

If one of your dependents becomes ineligible, his/her coverage will end as of the date the event occurs which makes him/her ineligible (for example, date of marriage, date of divorce) or a date determined by your Group. Coverage for a dependent child who reaches the limiting age will end as specified above under the heading ''Family Coverage.''

Your coverage (and the coverage of all of your family members) will be terminated, at the Plan's option, for failure to pay any required premium or charge, or for fraud or material misrepresentation in enrollment or in the use of services or facilities.

Benefits will not be provided for any services or supplies received after the date your coverage terminates under this Certificate unless specifically stated otherwise in the benefit sections of this Certificate or below under the heading Extension of Benefits in Case of Discontinuance of Coverage. However, termination of your coverage will not affect your benefits for any services or supplies that you received prior to your termination date.

Termination of your Group's Policy automatically terminates your coverage under this Certificate. It is your Group's responsibility to inform you of the

termination of the Group Policy but your coverage will be terminated regardless of whether or not such notice is given.

Upon termination of your coverage under this Certificate, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your dependent's coverage under this Certificate.

Extension of Benefits in Case of Discontinuance of Coverage

If you are Totally Disabled at the time your entire Group terminates, benefits will be provided for (and limited to) the Covered Services described in this Certificate which are related to the disability. Benefits will be provided when no coverage is available under the succeeding carrier's policy whether due to the absence of coverage in the policy or lack of required Creditable Coverage for a preexisting condition. Benefits will be provided for a period of no more than 12 months from the date of termination. These benefits are subject to all of the terms and conditions of this Certificate including, but not limited to, the requirements regarding Primary Care Physician referral. It is your responsibility to notify the Plan, and to provide, when requested by the Plan, written documentation of your disability. This extension of benefits does not apply to the benefits provided in the following Benefit Section(s) of this Certificate:

- Outpatient Prescription Drug Program Benefits

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE RIGHTS UNDER COBRA. See your employer or Group Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

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

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

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's

spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

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

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

COVERAGE AFTER TERMINATION (Illinois State Laws)

The purpose of this section of your Certificate is to explain the options available for continuing your coverage after termination, as it relates to Illinois state legis-

lation. The provisions which apply to you will depend upon your status at the time of termination. The provisions described in Article A will apply if you are the Eligible Person (as specified in the Group Policy) at the time of termination. The provisions described in Article B will apply if you are the spouse of a retired Eligible Person and are at least 55 years of age or the former spouse of an Eligible Person who has died or from whom you have been divorced. The provisions described in Article C will apply if you are the dependent child of an Eligible Person who has died or if you have reached the limiting age under this Certificate and not eligible to continue coverage as provided under Article B.

Your continued coverage under this Certificate will be provided only as specified below. Therefore, after you have determined which Article applies to you, please read the provisions very carefully.

ARTICLE A: **Continuation of coverage if you are the Eligible Person**

If an Eligible Person's coverage under this Certificate should terminate because of termination of employment or membership or because of a reduction in hours below the minimum required for eligibility, an Eligible Person will be entitled to continue the Hospital, Physician and Supplemental coverage provided under this Certificate for himself/herself and his/her eligible dependents (if he/she had Family Coverage on the date of termination). However, this continuation of coverage option is subject to the following conditions:

1. Continuation of coverage will be available to you only if you have been continuously insured under the Group Policy (or for similar benefits under any group policy which it replaced) for at least 3 months prior to your termination date or reduction in hours below the minimum required for eligibility.
2. Continuation of coverage will not be available to you if: (a) you are covered by Medicare or (b) you have coverage under any other health care program which provides group hospital, surgical or medical coverage and under which you were not covered immediately prior to such termination or reduction in hours below the minimum required for eligibility, or (c) you decide to become a member of the Plan on a ''direct pay'' basis.
3. If you decide to become a member of the Plan on a ''direct pay'' basis, you may not, at a later date, elect the continuation of coverage option under this Certificate. Upon termination of the continuation of coverage period as explained in paragraph 6 below, you may exercise the Conversion Privilege explained in the ELIGIBILITY section of this Certificate.
4. Upon termination of employment or membership or reduction in hours below the minimum required for eligibility, your Group will provide you with written notice of this option to continue your coverage. If you decide to continue your coverage, you must notify your Group, in writing, no later than 10 days after your coverage has terminated or reduction in hours below the minimum required for eligibility or 10 days after the date you received notice from your Group of this option to continue coverage. However, in no event will you be entitled to your continuation of coverage option more than 60 days after your termination or reduction in hours below the minimum required for eligibility.

5. If you decide to continue your coverage under this Certificate, you must pay your Group on a monthly basis, in advance, the total charge required by the Plan for your continued coverage, including any portion of the charge previously paid by your Group. Payment of this charge must be made to the Plan (by your Group) on a monthly basis, in advance, for the entire period of your continuation of coverage under this Certificate.
6. Continuation of coverage under this Certificate will end on the date you become eligible for Medicare, become a member of the Plan on a "direct pay" basis or become covered under another health care program (which you did not have on the date of your termination or reduction in hours below the minimum required for eligibility) which provides group hospital, surgical or medical coverage. However, your continuation of coverage under this Certificate will also end on the first to occur of the following:
    a. Nine months after the date the Eligible Person's coverage under this Certificate would have otherwise ended because of termination of employment or membership or reduction in hours below the minimum required for eligibility.
    b. If you fail to make timely payment of required charges, coverage will terminate at the end of the period for which your charges were paid.
    c. The date on which the Group Policy is terminated. However, if this Certificate is replaced by similar coverage under another group policy, the Eligible Person will have the right to become covered under the new coverage for the amount of time remaining in the continuation of coverage period.

ARTICLE B: **Continuation of Coverage if you are the former spouse of an Eligible Person or spouse of a retired Eligible Person**

If the coverage of the spouse of an Eligible Person should terminate because of the death of the Eligible Person, a divorce from the Eligible Person, or the retirement of an Eligible Person, the former spouse or retired Eligible Person's spouse if at least 55 years of age, will be entitled to continue the coverage provided under this Certificate for himself/herself and his/her eligible dependents (if Family Coverage is in effect at the time of termination). However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to you as the former spouse of an Eligible Person or spouse of a retired Eligible Person only if you provide the employer of the Eligible Person with written notice of the dissolution of marriage, the death or retirement of the Eligible Person within 30 days of such event.
2. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to the Plan of the dissolution of your marriage to the Eligible Person, the death of the Eligible Person or the retirement of the Eligible Person as well as notice of your address. Such notice will include the Group number and the Eligible Person's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, the Plan will advise you at your residence, by certified mail, return receipt requested, that your coverage and your covered dependents

under this Certificate may be continued. The Plan's notice to you will include the following:

a. a form for election to continue coverage under this Certificate.

b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.

c. instructions for returning the election form within 30 days after the date it is received from the Plan.

3. In the event you fail to provide written notice to the Plan within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a former spouse or spouse of a retired Eligible Person under this Certificate as a result of the dissolution of marriage, the death or the retirement of the Eligible Person. Your right to continuation of coverage will then be forfeited.

4. If the Plan fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of the Plan's notice was to be sent are terminated as to all Eligible Persons under this Certificate.

5. If you have not reached age 55 at the time your continued coverage begins, the monthly charge will be computed as follows:

   a. an amount, if any, that would be charged to you if you were an Eligible Person, with Individual or Family Coverage, as the case may be, plus

   b. an amount, if any, that the employer would contribute toward the charge if you were the Eligible Person under this Certificate.

   Failure to pay the initial monthly charge within 30 days after receipt of notice from the Plan as required in this Article will terminate your continuation benefits and the right to continuation of coverage.

6. If you have reached age 55 at the time your continued coverage begins, the monthly charge will be computed for the first 2 years as described above. Beginning with the third year of continued coverage, an additional charge, not to exceed 20% of the total amounts specified in (5) above will be charged for the costs of administration.

7. Termination of Continuation of Coverage:

   If you have not reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

   a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).

   b. on the date coverage would otherwise terminate under this Certificate if you were still married to the Eligible Person; however, your coverage shall not be modified or terminated during the first 120

consecutive days following the Eligible Person's death or entry of judgment dissolving the marriage existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.

c. the date on which you remarry.

d. the date on which you become an insured employee under any other group health plan.

e. the expiration of 2 years from the date your continued coverage under this Certificate began.

8. If you have reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

   a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).

   b. on the date coverage would otherwise terminate, except due to the retirement of the Eligible Person under this Certificate if you were still married to the Eligible Person; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Eligible Person's death, retirement or entry of judgment dissolving the marriage existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.

   c. the date on which you remarry.

   d. the date on which you become an insured employee under any other group health plan.

   e. the date upon which you reach the qualifying age or otherwise establish eligibility under Medicare.

9. If you exercise the right to continuation of coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other Eligible Person covered under this Certificate, except as specifically stated in these provisions.

10. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of the Plan on a ''direct pay'' basis as specified in the Conversion Privilege of the ELIGIBILITY section of this Certificate.

11. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

ARTICLE C: **Continuation of Coverage if you are the dependent child of an Eligible Person**

If the coverage of a dependent child should terminate because of the death of the Eligible Person and the dependent child is not eligible to continue coverage under ARTICLE B or the dependent child has reached the limiting age under this Certif-

icate, the dependent child will be entitled to continue the coverage provided under this Certificate for himself/herself. However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to you as the dependent child of an Eligible Person only if you, or a responsible adult acting on your behalf as the dependent child, provide the employer of the Eligible Person with written notice of the death of the Eligible Person within 30 days of the date the coverage terminates.
2. If continuation of coverage is desired because you have reached the limiting age under this Certificate, you must provide the employer of the Eligible Person with written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.
3. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to the Plan of the death of the Eligible Person or of the dependent child reaching the limiting age, as well as notice of the dependent child's address. Such notice will include the Group number and the Eligible Person's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, the Plan will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. The Plan's notice to you will include the following:
    a. a form for election to continue coverage under this Certificate.
    b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.
    c. instructions for returning the election form within 30 days after the date it is received from the Plan.
4. In the event you, or the responsible adult acting on your behalf as the dependent child, fail to provide written notice to the Plan within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a dependent child of an Eligible Person under this Certificate as a result of the death of the Eligible Person or the dependent child attaining the limiting age. Your right to continuation of coverage will then be forfeited.
5. If the Plan fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of the Plan's notice was to be sent are terminated as to all Eligible Persons under this Certificate.
6. The monthly charge will be computed as follows:
    a. an amount, if any, that would be charged to you if you were an Eligible Person, plus
    b. an amount, if any, that the employer would contribute toward the charge if you were the Eligible Person under this Certificate.

Failure to pay the initial monthly charge within 30 days after receipt of notice from the Plan as required in this Article will terminate your continuation benefits and the right to continuation of coverage.

7. Continuation of Coverage shall end on the first to occur of the following:
    a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
    b. on the date coverage would otherwise terminate under this Certificate if you were still an eligible dependent child of the Eligible Person.
    c. the date on which you become an insured employee, after the date of election, under any other group health plan.
    d. the expiration of 2 years from the date your continued coverage under this Certificate began.
8. If you exercise the right to continuation of coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other Eligible Person covered under this Certificate, except as specifically stated in these provisions.
9. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of the Plan on a ''direct pay'' basis as specified in the Conversion Privilege of the ELIGIBILITY section of this Certificate.
10. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

Other options that may be available for continuation of coverage are explained in the Continuation of Coverage sections of this Certificate.

CONVERSION

In addition to the option of continuing your Group coverage after termination, you have the option of converting your Group coverage to direct-payment coverage. This option, conversion privilege, is explained below.

If you choose to convert your Group coverage to direct-payment coverage, you may not, at a later date, select the continuation of group coverage option. However, the conversion privilege will be available when the continuation of coverage period ends.

CONVERSION PRIVILEGE

If, at the time that your coverage under this Certificate is terminated, you have been covered for at least three months, either as an Eligible Person or a dependent of an Eligible Person, you may convert your coverage to the coverage that the Plan has available for persons who are no longer members of a group.

In order to convert your coverage you should:

— Contact the Plan to get an application.

— Send the application to the Plan within 31 days of the date that your coverage is terminated.

Having done so, you will then be covered by the Plan on an individual ''direct-payment'' basis. Your converted coverage will be effective from the date that your Group coverage terminates as long as you pay the required premiums when due.

The converted coverage may require copayments and/or deductibles that are different from those of this Certificate. The converted coverage will provide, at minimum, benefits for basic health care services as defined in the HMO Act.

The Plan is not required to offer conversion coverage to you if you no longer live within the service area of a Participating IPA or Participating Medical Group. However, if you have similar benefits under a group arrangement that does not cover pre-existing conditions, and you have a pre-existing condition, you can continue conversion coverage until your pre-existing condition is covered under that group arrangement.

Conversion coverage is not available when your Group terminates its coverage under this Certificate and replaces it with other coverage or when your coverage has been terminated for: failure to pay a required premium or charge; fraud or material misrepresentation in enrollment or in the use of services or facilities.

YOUR PRIMARY CARE PHYSICIAN

YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER IS AN INDEPENDENT CONTRACTOR, NOT AN EMPLOYEE OR AGENT OF YOUR BLUE CROSS HMO. YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER RENDERS AND COORDINATES YOUR MEDICAL CARE. YOUR BLUE CROSS HMO IS YOUR BENEFIT PROGRAM, NOT YOUR HEALTH CARE PROVIDER.

At the time that you applied for this coverage, you selected a Participating Individual Practice Association (IPA) and a Primary Care Physician or a Participating Medical Group. If you enrolled in Family Coverage, then members of your family may select a different Participating IPA/Participating Medical Group. You must choose a Primary Care Physician for each of your family members from the selected Participating IPA/Participating Medical Group. In addition, female members also may choose a Woman's Principal Health Care Provider. A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must have a referral arrangement with one another. Contact your Participating IPA/Participating Medical Group, your Primary Care Physician or Woman's Principal Health Care Provider or the Plan for a list of Providers with whom your Primary Care Physician and/or your Woman's Principal Health Care Provider has a referral arrangement.

Your Primary Care Physician and/or your Woman's Principal Health Care Provider is affiliated with or employed by your Participating IPA or Participating Medical Group. Your Primary Care Physician is responsible for coordinating all of your health care needs. In the case of female members, your health care needs may be coordinated by your Primary Care Physician and/or your Woman's Principal Health Care Provider.

TO BE ELIGIBLE FOR THE BENEFITS OF THIS CERTIFICATE, THE SERVICES THAT YOU RECEIVE MUST BE PROVIDED BY OR ORDERED BY YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER.

To receive benefits for treatment from another Physician or Provider, you must be referred to that Provider by your Primary Care Physician or Woman's Principal Health Care Provider. That referral must be in writing and must specifically state the services that are to be rendered. Benefits will be limited to those specifically stated services.

If you have an illness or injury that needs ongoing treatment from another Physician or Provider, you may apply for a Standing Referral to that Physician or Provider from your Primary Care Physician or Woman's Principal Health Care Provider. Your Primary Care Physician or Woman's Principal Health Care Provider may authorize the Standing Referral which shall be effective for the period necessary to provide the referred services or up to a period of one year.

The only time that you can receive benefits for services not ordered by your Primary Care Physician or Woman's Principal Health Care Provider is when you are

receiving either emergency care, Chemical Dependency Treatment, treatment for Mental Illness other than Serious Mental Illness or routine vision examinations. These benefits are explained in detail in the EMERGENCY CARE BENEFITS, CHEMICAL DEPENDENCY TREATMENT BENEFITS, HOSPITAL BENEFITS sections and, for routine vision examinations or Mental Illness other than Serious Mental Illness, in the PHYSICIAN BENEFITS section of this Certificate. It is important that you understand the provisions of those sections.

PLEASE NOTE, BENEFITS WILL NOT BE PROVIDED FOR SERVICES OR SUPPLIES THAT ARE NOT LISTED AS COVERED SERVICES IN THIS CERTIFICATE, EVEN IF THEY HAVE BEEN ORDERED BY YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER.

Changing Your Primary Care Physician or Woman's Principal Health Care Provider

You may change your choice of Primary Care Physician or Woman's Principal Health Care Provider to one of the other Physicians in your Participating IPA or Participating Medical Group by notifying your Participating IPA/Participating Medical Group of your desire to change. Contact your Participating IPA/Participating Medical Group, your Primary Care Physician or Woman's Principal Health Care Provider or the Plan to obtain a list of providers with whom your Primary Care Physician and/or Woman's Principal Health Care Provider have a referral arrangement.

Changing Your Participating IPA/Participating Medical Group

You may change from your Participating IPA/Participating Medical Group to another Participating IPA/Participating Medical Group by calling the Plan at 1-800-892-2803.

The change will be effective the first day of the month following your call. However, if you are an Inpatient or in the third trimester of pregnancy at the time of your request, the change will not be effective until you are no longer an Inpatient or until your pregnancy is completed.

When necessary, Participating IPAs/Participating Medical Groups have the right to request the removal of members from their enrollment. Their request cannot be based upon the type, amount or cost of services required by any member. If the Plan determines that the Participating IPA/Participating Medical Group has sufficient cause and approves such a request, such members will be offered enrollment in another Participating IPA or Participating Medical Group or enrollment in any other health care coverage then being provided by their Group, subject to the terms and conditions of such other coverage. The change will be effective no later than the first day of the month following 45 days from the date the request is received.

Selecting a Different Participating IPA/Participating Medical Group for Your Newborn

You may select a Participating IPA/Participating Medical Group for your newborn child. Your newborn will remain with the mother's Participating IPA/Participating Medical Group/Woman's Principal Health Care Provider, if one has been selected, from the date of birth to the end of the month in which he/she is discharged from the Hospital. Your newborn may be added to the selected Participating IPA/Participating Medical Group on the first day of the month following discharge from the Hospital.

Transition of Care Benefits

If you are a new HMO enrollee and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy, and your Physician does not belong to the Plan's network, but is within the Plan's service area, you may request the option of transition of care benefits. You must submit a written request to the Plan for transition of care benefits within 15 business days of your eligibility effective date.

If you are a current HMO enrollee and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy and your Primary Care Physician or Woman's Principal Health Care Provider leaves the Plan's network, you may request the option of transition of care benefits. You must submit a written request to the Plan for transition of care benefits within 30 business days after receiving notification of your Primary Care Physician or Woman's Principal Health Care Provider's termination.

The Plan may authorize transition of care benefits for a period up to 90 days. Authorization of benefits is dependent on the Physician's agreement to contractual requirements and submission of a detailed treatment plan.

A written notice of the Plan's determination will be sent to you within 15 business days of receipt of your request.

PHYSICIAN BENEFITS

This section of your Certificate explains what your benefits are when you receive care from a Physician.

Remember, to receive benefits for Covered Services, (except for the treatment of Mental Illness other than Serious Mental Illness), they must be performed by or ordered by your Primary Care Physician or Woman's Principal Health Care Provider. In addition, only services performed by Physicians are eligible for benefits unless another Provider, for example, a Dentist, is specifically mentioned in the description of the service.

Whenever we use "you" or "your" in describing your benefits, we mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Your coverage includes benefits for the following Covered Services:

Surgery — when performed by a Physician, Dentist or Podiatrist.

However, benefits for oral Surgery are limited to the following services:

1. surgical removal of completely bony impacted teeth;
2. excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

— **Anesthesia** — if administered in connection with a covered surgical procedure by a Physician, Dentist or Podiatrist other than the operating surgeon or by a Certified Registered Nurse Anesthetist.

  In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability that is the result of a mental or physical impairment, is likely to continue and that substantially limits major life activities such as self-care, receptive and expressive language, learning, mobility, capacity for independent living or economic self-sufficiency or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

— **An assistant surgeon** — that is, a Physician, Dentist or Podiatrist who actively assists the operating surgeon in the performance of a covered surgical procedure.

Medical Care

Benefits will be provided for Medical Care rendered to you:

— when you are an Inpatient in a Hospital or Skilled Nursing Facility;

— when you are a patient in a Partial Hospitalization Treatment Program or Home Health Care Program; or

— on an Outpatient basis in your Physician's office or your home.

Medical Care visits will only be covered for as long as your stay in a particular facility or program is eligible for benefits (as specified in the HOSPITAL BENEFITS section of this Certificate).

Benefits for the treatment of Mental Illness is also a benefit under your Medical Care coverage. In addition to a Physician, Mental Illness rendered under the supervision of a Physician by a clinical social worker or other mental health professional is covered.

Consultations — that is, examination and/or treatment by a Physician to obtain his/her advice in the diagnosis or treatment of a condition which requires special skill or knowledge.

Mammograms — Benefits will be provided for mammograms for all women. A mammogram is an x-ray or digital examination of the breast for the presence of breast cancer, even if no symptoms are present. Benefits for mammograms will be provided as follows:

— one baseline mammogram

— an annual mammogram

Benefits for mammograms will be provided for women who have a family history of breast cancer or other risk factors at the age and intervals as often as your Primary Care Physician or Woman's Principal Health Care Provider finds necessary.

If a mammogram reveals heterogeneous or dense breast tissue, benefits will be provided for a comprehensive ultrasound screening of an entire breast or breasts as determined by your Primary Care Physician or Woman's Principal Health Care Provider.

Outpatient Periodic Health Examinations — including the taking of your medical history, physical examination and any diagnostic tests necessary because of your age, sex, medical history or physical condition. You are eligible for these examinations as often as your Primary Care Physician or Woman's Principal Health Care Provider, following generally accepted medical practice, finds necessary.

Covered Services include, but are not limited to:

— clinical breast examinations;

— routine cervical smears or Pap smears;

— routine prostate-specific antigen tests and digital rectal examinations;

— colorectal cancer screening — as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer

screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology; and

— ovarian cancer screening — using CA-125 serum tumor marker testing, transvaginal ultrasound and pelvic examination.

Benefits will also be provided for pre-marital examinations that are required by state or federal law. Benefits are not available for examinations done for insurance or employment screening purposes.

Routine Pediatric Care — that is, the routine health care of infants and children including examinations, tests, immunizations and diet regulation. Children are eligible for benefits for these services as often as is felt necessary by their Primary Care Physician.

Benefits will also be provided for pre-school or school examinations that are required by state or federal law. Benefits are not available for recreational/camp physicals or sports physicals.

Diagnostic Services — these services will be covered when rendered by a Dentist or Podiatrist, in addition to a Physician, but only when they are rendered in connection with covered Surgery.

Injected Medicines — that is, drugs that cannot be self-administered and which must be administered by injection. Benefits will be provided for the drugs and the administration of the injection. This includes routine immunizations and injections that you may need for traveling.

In addition, benefits will be provided for a human papillomavirus (HPV) vaccine and a shingles vaccine approved by the federal Food and Drug Administration.

Amino Acid-Based Elemental Formulas — Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome.

Electroconvulsive Therapy — including benefits for anesthesia administered with the electroconvulsive therapy if the anesthesia is administered by a Physician other than the one administering the therapy.

Radiation Therapy — that is, the use of ionizing radiation in the treatment of a medical illness or condition.

Chemotherapy — that is, the treatment of malignancies with drugs.

Outpatient Rehabilitative Therapy — including, but not limited to, Speech Therapy, Physical Therapy and Occupational Therapy. Treatment, as determined by your Primary Care Physician or Woman's Principal Health Care Provider, must be either (a) limited to therapy which is expected to result in significant improvement within two months in the condition for which it is rendered, or (b) prescribed as preventive or Maintenance Physical Therapy for members affected by multiple sclerosis, subject to the benefit maximum. Benefits for Outpatient rehabilitative therapy are limited to a combined maximum of 60 treatments per calendar year.

Outpatient Speech Therapy for Pervasive Developmental Disorders — Benefits will be provided for Outpatient Speech Therapy visits for pervasive developmental disorders per calendar year as determined by your Primary Care Physician or Woman's Principal Health Care Provider. These visits are in addition to the maximum as previously described for Outpatient rehabilitative therapy.

Outpatient Respiratory Therapy — when rendered for the treatment of an illness or injury by or under the supervision of a qualified respiratory therapist.

Chiropractic and Osteopathic Manipulation — Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures.

Hearing Screening — when done to determine the need for hearing correction. Benefits will not be provided for hearing aids, unless otherwise specified in this Certificate.

Diabetes Self-Management Training and Education — benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management. Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Routine Vision Examinations — benefits will be provided for a routine vision examination, limited to one visit per a 12 month period, without a referral from your Primary Care Physician or Woman's Principal Health Care Provider for vision examinations done to determine the need for vision correction including determination of the nature and degree of refractive errors of the eyes.

The examination must be rendered by an Optometrist or Physician who has an agreement with the Plan, directly or indirectly, to provide routine vision examinations to you. Routine vision examinations do not include medical or surgical treatment of eye diseases or injuries.

Benefits will not be provided for eyeglasses or contact lenses, unless otherwise specified in this Certificate.

Dental Accident Care — that is, dental services rendered by a Dentist or Physician which are required as the result of an accidental injury. However, these services are covered only if the injury is to sound natural teeth. A sound natural tooth is any tooth that has an intact root or is part of a permanent bridge.

Family Planning Services — including family planning counseling, prescribing of contraceptive drugs, fitting of contraceptive devices and sterilization. See Outpatient Contraceptive Services below for additional benefits.

Benefits are not available under this benefit section for the actual contraceptive drugs or for repeating or reversing sterilization.

Outpatient Contraceptive Services — Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Bone Mass Measurement and Osteoporosis — Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Investigational Cancer Treatment — Benefits will be provided for routine patient care in conjunction with investigational cancer treatments, when medically appropriate and you have a terminal condition related to cancer, that according to the diagnosis of your Physician is considered life threatening.

Infertility Treatment

Benefits will be provided for Covered Services rendered in connection with the diagnosis and/or treatment of infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection.

Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one year requirement will be waived if your Physician determines that a medical condition exists that renders conception impossible through unprotected sexual intercourse, including but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, involuntary sterilization due to Chemotherapy or radiation treatments; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

Unprotected sexual intercourse means sexual union between a male and a female, without the use of any process, device or method that prevents conception, including but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

Benefits for treatments that include oocyte retrievals will be provided only when:

— you have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that renders such treatment useless); and

— you have not undergone four (4) completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two (2) more completed oocyte retrievals shall be covered.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures utilized to retrieve oocytes or sperm, and the subsequent procedure

used to transfer the oocytes or sperm to you. Associated donor medical expenses are also covered, including but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.

The maximum number of completed oocyte retrievals you are eligible for under, this Certificate, in your lifetime is six. Following the final completed oocyte retrieval, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you. Thereafter, you will have no benefits for infertility treatment.

Benefits will not be provided for the following:

1. Reversal of voluntary sterilization. However, in the event a voluntary sterilization is successfully reversed, benefits will be provided if your diagnosis meets the definition of "infertility" as stated above.
2. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate.
3. Selected termination of an embryo in cases where the mother's life is not in danger.
4. Cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
5. Non-medical costs of an egg or sperm donor.
6. Travel costs for travel within 100 miles of the covered person's home or which is not medically necessary or which is not required by the Plan.
7. Infertility treatments which are determined to be Investigational, in writing, by the American Society for Reproductive Medicine or American College of Obstetrics and Gynecology.
8. Infertility treatment rendered to your dependents under the age of 18.

In addition to the above provisions, in vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.

Mastectomy Related Services

Benefits will be provided for Covered Services related to mastectomies, including, but not limited to, 1) reconstruction of the breast on which the mastectomy has been performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) post mastectomy care for inpatient treatment for a length of time determined by the attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation, and a follow-up Physician office visit or in-home nurse visit within forty-eight (48) hours after discharge; and 4) prostheses and

physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.

Maternity Services

Your benefits for maternity services are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will be provided for delivery charges and for any of the previously described Covered Services when rendered in connection with pregnancy. Benefits will be provided for any treatment of an illness, injury, congenital defect, birth abnormality or a premature birth from the moment of the birth up to the first 31 days, thereafter, you must add the newborn child to your Family Coverage. Premiums will be adjusted accordingly.

Coverage will be provided for the mother and the newborn for a minimum of:

1. 48 hours of inpatient care following a vaginal delivery, or
2. 96 hours of inpatient care following a delivery by caesarean section,

except as may be indicated by the following: A shorter length of hospital inpatient stay related to maternity and newborn care may be provided if the attending physician determines, in accordance with the protocols and guidelines developed by the American College of Obstetrics and Gynecology or by the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for a shorter length of stay based upon evaluation of the mother and newborn. Such an earlier discharge may only be provided if there is coverage and availability of a post-discharge physician office visit or an in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge.

Your coverage also includes benefits for elective abortions, if legal where performed, limited to a lifetime maximum of two abortions.

Please note, as with all other services, benefits will only be provided for maternity services and/or care of the newborn child when such services have been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider. If you choose to have your obstetrical or pediatric care rendered by a Physician whose services have not been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider, the Plan will neither provide benefits for such care nor coordinate benefits with any other health care coverage that you may have.

URGENT CARE

This benefit provides medically necessary outpatient care if you are outside the Plan's service area and experience an unexpected illness or injury that would not be considered an Emergency Condition, but which should be treated before returning home. Services usually are provided at a Physician's office. If you require such Urgent Care, you should contact 1-800-810-BLUE. You will be given the names and addresses of nearby participating Physicians and Hospitals that you can contact to arrange an appointment for Urgent Care.

Payment for Urgent Care Treatment

100% of the Provider's Charge will be paid for Urgent Care received outside of the Plan's service area. You will be responsible for any Copayment(s), if applicable.

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the HOSPITAL BENEFITS and PHYSICIAN BENEFITS sections of this Certificate. Your Primary Care Physician or Woman's Principal Health Care Provider is responsible for coordinating all of your health care needs. Therefore, it is especially important for you or your family to contact your Primary Care Physician or Woman's Principal Health Care Provider as soon as possible if Inpatient Hospital care is required.

FOLLOW-UP CARE

If you will be traveling and know that you will require follow-up care for an existing condition, contact 1-800-810-BLUE. You will be given the names and addresses of nearby participating Physicians that you can contact to arrange the necessary follow-up care. (Examples of follow-up care include removal of stitches, removal of a cast, Physical Therapy, monitoring blood tests, and kidney dialysis.)

Payment for Follow-Up Care Treatment

100% of the Provider's Charge will be paid for follow-up care received outside of the Plan's service area. You will be responsible for any Copayment(s), if applicable.

COST TO YOU FOR PHYSICIAN SERVICES

The Covered Services of this benefit section are covered in full, with no cost to you, except as follows:

Benefits for all Outpatient office visits, except for Surgery or maternity services after the first pre-natal visit, are subject to a Copayment of $20 per visit, unless otherwise specified in this Certificate, and then will be paid in full when such services are received from a:

- Physician
- Physician Assistant
- Certified Nurse Midwife
- Certified Nurse Practitioner
- Certified Registered Nurse Anesthetist
- Certified Clinical Nurse Specialist
- Marriage and Family Therapist

Benefits for Outpatient office visits for periodic health examinations, routine pediatric care and routine vision examinations are subject to a Copayment of $20 per visit and then will be paid in full.

Benefits for Outpatient visits to a Specialist Physician's office are subject to a Co-payment of $20 per visit and then will be paid in full.

Benefits for Outpatient office visits for the treatment of Mental Illness other than Serious Mental Illness will be provided at 50% of Covered Services when such treatment is not authorized by your Primary Care Physician or Woman's Principal Health Care Provider.

HOSPITAL BENEFITS

This section of your Certificate explains what your benefits are when you receive care in a Hospital or other health care facility. Benefits are only available for services rendered by a Hospital unless another Provider is specifically mentioned in the description of the service.

Remember, to receive benefits for Covered Services, (except for Mental Illness other than Serious Mental Illness), they must be ordered or approved by your Primary Care Physician or Woman's Principal Health Care Provider.

Whenever we use "you" or "your" in describing your benefits, we mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Inpatient Care

You are entitled to benefits for the following services when you are an Inpatient in a Hospital or Skilled Nursing Facility:

1. **Bed, board and general nursing care** when you are in:
   - — a semi-private room or a private room – must be ordered by your Primary Care Physician or Woman's Principal Health Care Provider.
   - — an intensive care unit.
2. **Ancillary services** (such as operating rooms, drugs, surgical dressings and lab work).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

Number of Inpatient Days

There are no limits on the number of days available to you for Inpatient care in a Hospital or other eligible facility.

Outpatient Care

You are entitled to benefits for the following services when you receive them from a Hospital, or other specified Provider, on an Outpatient basis:

1. **Surgery** — when performed in a Hospital or Ambulatory Surgical Facility.
2. **Diagnostic Services** — that is, tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury.
3. **Radiation Therapy** — that is, the use of ionizing radiation in the treatment of a medical illness or condition.
4. **Chemotherapy** — that is, the treatment of malignancies with drugs.
5. **Electroconvulsive Therapy**

6. **Renal Dialysis Treatments and Continuous Ambulatory Peritoneal Dialysis Treatment** — when received in a Hospital or a Dialysis Facility. Benefits for treatment in your home are available if you are homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and are rendered under the supervision of a Hospital or Dialysis Facility health care professional.

Special Programs

You are entitled to benefits for the special programs listed below. The services covered under these programs are the same as those that are available when you are an Inpatient in a Hospital. These programs are as follows:

1. **Coordinated Home Care Program**
2. **Pre-Admission Testing** — This is a program in which preoperative tests are given to you as an Outpatient in a Hospital to prepare you for Surgery that you are scheduled to have as an Inpatient.
3. **Partial Hospitalization Treatment Program** — This is a therapeutic treatment program in a Hospital for patients with Mental Illness.

Surgical Implants

Your coverage includes benefits for surgically implanted internal and permanent devices. Examples of these devices are internal cardiac valves, internal pacemakers, mandibular reconstruction devices, bone screws and vitallium heads for joint reconstruction.

Maternity Services

Your benefits for services rendered in connection with pregnancy are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. In addition to all of the previously described Covered Services, routine Inpatient nursery charges for the newborn child are covered, even under Individual Coverage. (If the newborn child needs treatment for an illness, injury, congenital defect, birth abnormality or a premature birth, that care will be covered from the moment of birth up to the first 31 days, thereafter, you must add the newborn child to your Family Coverage. Premiums will be adjusted accordingly.

Coverage will be provided for the mother and the newborn for a minimum of:

1. 48 hours of inpatient care following a vaginal delivery, or
2. 96 hours of inpatient care following a delivery by caesarean section,

except as may be indicated by the following: A shorter length of hospital inpatient stay related to maternity and newborn care may be provided if the attending physician determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or by the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for a shorter length of stay based upon evaluation of the mother and newborn. Such an earlier discharge may only be required if there is coverage and

availability of a post-discharge physician office visit or an in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge.

Your coverage also includes benefits for elective abortions, if legal where performed, limited to a lifetime maximum of two abortions.

Please note, as with all other services, benefits will only be provided for maternity services and/or care of the newborn child when such services have been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider. If you choose to have your obstetrical or pediatric care rendered by a Physician whose services have not been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider, the Plan will neither provide benefits for such care nor coordinate benefits with any other health care coverage that you may have.

URGENT CARE

This benefit provides medically necessary outpatient care if you are outside the Plan's service area and experience an unexpected illness or injury that would not be considered an Emergency Condition, but which should be treated before returning home. Services usually are provided at a Physician's office. If you require such Urgent Care, you should contact 1-800-810-BLUE. You will be given the names and addresses of nearby participating Physicians and Hospitals that you can contact to arrange an appointment for Urgent Care.

Payment for Urgent Care Treatment

100% of the Provider's Charge will be paid for Urgent Care received outside of the Plan's service area. You will be responsible for any Copayment(s), if applicable.

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the HOSPITAL BENEFITS and PHYSICIAN BENEFITS sections of this Certificate. Your Primary Care Physician or Woman's Principal Health Care Provider is responsible for coordinating all of your health care needs. Therefore, it is especially important for you or your family to contact your Primary Care Physician or Woman's Principal Health Care Provider as soon as possible if Inpatient Hospital care is required.

FOLLOW-UP CARE

If you will be traveling and know that you will require follow-up care for an existing condition, contact 1-800-810-BLUE. You will be given the names and addresses of nearby participating Physicians that you can contact to arrange the necessary follow-up care. (Examples of follow-up care include removal of stitches, removal of a cast, Physical Therapy, monitoring blood tests, and kidney dialysis.)

Payment for Follow-Up Care Treatment

100% of the Provider's Charge will be paid for follow-up care received outside of the Plan's service area. You will be responsible for any Copayment(s), if applicable.

BENEFIT PAYMENT FOR HOSPITAL SERVICES

100% of the Provider's Charge will be paid when you receive the Covered Services of this benefit section, except as specifically mentioned below.

50% of the Provider's Charge will be paid when you receive Covered Services for the Inpatient treatment of Mental Illness other than Serious Mental Illness, when not authorized by your Primary Care Physician or Woman's Principal Health Care Provider.

SUPPLEMENTAL BENEFITS

When you are being treated for an illness or injury, your treatment may require the use of certain special services or supplies in addition to those provided in the other benefit sections of this Certificate. Your coverage includes benefits for certain supplemental services and supplies and this section of your Certificate explains what those benefits are.

Remember, these services and supplies must be provided or ordered by your Primary Care Physician or Woman's Principal Health Care Provider.

COVERED SERVICES

Your coverage includes benefits for the following Covered Services:

- **Blood and Blood Components**
- **Medical and Surgical Dressings, Supplies, Casts and Splints**
- **Prosthetic Devices** — benefits will be provided for prosthetic devices, special appliances and surgical implants required for an illness or injury when:
  1. they are required to replace all or part of an organ or tissue of the human body; or
  2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

  Adjustments, repairs and replacements of these devices, appliances and implants are also covered when required because of wear or a change in your condition. Benefits will not be provided for dental appliances or hearing aids, except for bone anchored hearing aids (osseointegrated auditory implants), or for replacement of cataract lenses unless a prescription change is required.
- **Orthotic Devices** — that is, a supportive device for the body or a part of the body, head, neck or extemities including, but not limited to leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition as determined by your Primary Care Physician or Woman's Principal Health Care Provider. Benefits will not be provided for foot orthotics defined as an in-shoe device designed to support the foot during weight-bearing activities.
- **Durable Medical Equipment** — that is, durable equipment which primarily serves a medical purpose, is appropriate for home use and generally is not useful in the absence of injury or disease. Benefits will be provided for the rental of a piece of equipment (not to exceed the total cost of equipment) or purchase of the equipment. Durable medical equipment must be rented or purchased from a Plan contracting durable medical equipment provider. Contact your Participating IPA/Participating Medical Group prior to purchasing or renting such equipment.

  Examples of durable medical equipment are wheelchairs, hospital beds, glucose monitors and ventilators. Benefits will not be provided for strollers,

electric scooters, back-up or duplicate equipment, ramps or other environmental devices, or clothing or special shoes.

PAYMENT FOR COVERED SERVICES

100% of the Provider's Charge will be paid for the Covered Services specified above.

EMERGENCY CARE BENEFITS

This section of your Certificate explains your emergency care benefits.

IN-AREA TREATMENT OF AN EMERGENCY

You are considered to be in your Participating IPA's/Participating Medical Group's treatment area if you are within 30 miles of your Participating IPA/Participating Medical Group.

Although you may go directly to the nearest Hospital emergency room to obtain treatment for an Emergency Condition, we recommend that you contact your Primary Care Physician or Woman's Principal Health Care Provider first if you are in your Participating IPA's/Participating Medical Group's treatment area. Benefits will be provided for the Hospital and Physician services that he/she authorizes.

If you obtain emergency treatment in the Hospital emergency room, your Primary Care Physician or Woman's Principal Health Care Provider must be notified of your condition as soon as possible and benefits will be limited to the initial treatment of your emergency unless further treatment is ordered by your Primary Care Physician or Woman's Principal Health Care Provider. If Inpatient Hospital care is required, it is especially important for you or your family to contact your Primary Care Physician or Woman's Principal Health Care Provider as soon as possible. All Participating IPA's/Participating Medical Groups have 24 hour phone service.

Payment for In-Area Emergency Treatment

Benefits for emergency treatment received in your Participating IPA's/Participating Medical Group's treatment area will be paid at 100% of the Provider's Charge.

However, each time you receive emergency treatment in a Hospital emergency room, you will be responsible for a Copayment of $75. The emergency room Copayment does not apply to services provided for the treatment of sexual assault.

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the Hospital Benefits and Physician Benefits Sections of this Certificate. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

OUT-OF-AREA TREATMENT OF AN EMERGENCY

If you are more than 30 miles away from your Participating IPA/Participating Medical Group and need to obtain treatment for an Emergency Condition, benefits will be provided for the Hospital and Physician services that you receive. Benefits are available for the initial treatment of the emergency and for related follow-up care but only if it is not reasonable for you to obtain the follow-up care from your Primary Care Physician or Woman's Principal Health Care Provider. If you are not sure whether or not you are in your Participating IPA's/Participating Medical Group's treatment area, call them and they will tell you.

Payment for Out-of-Area Emergency Treatment

Benefits for emergency treatment received outside of your Participating IPA's/ Participating Medical Group's treatment area will be paid at 100% of the Provider's Charge.

However, each time you receive emergency treatment in a Hospital emergency room, you will be responsible for a Copayment of $75. The emergency room Copayment does not apply to services provided for the treatment of sexual assault.

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the Hospital Benefits and Physician Benefits Sections of this Certificate. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

EMERGENCY AMBULANCE BENEFITS

Benefits for emergency ambulance transportation are available when:

1. such transportation is ordered by your Primary Care Physician or Woman's Principal Health Care Provider; or
2. the need for such transportation has been reasonably determined by a Physician, public safety official or other emergency medical personnel rendered in connection with an Emergency Condition.

Benefits are available for transportation between your home or the scene of an accident or medical emergency and a Hospital or Skilled Nursing Facility. If there are no facilities in the local area equipped to provide the care needed, benefits will be provided for transportation to the closest facility that can provide the necessary services. Only the use of a certified ground ambulance is covered.

100% of the Provider's Charge will be paid for emergency ambulance transportation.

CHEMICAL DEPENDENCY TREATMENT BENEFITS

Your coverage includes benefits for the treatment of Chemical Dependency.

Covered Services are the same as those provided for any other condition, as specified in the other benefit sections of this Certificate. In addition, benefits are available for Covered Services provided by a Chemical Dependency Treatment Facility in the HMO Illinois Chemical Dependency Network. To obtain benefits for Chemical Dependency Treatment, you must call the HMO Illinois Chemical Dependency Hotline at 1-800-346-3986.

Benefits are available through the HMO Illinois Chemical Dependency Network for the treatment of Chemical Dependency whether or not the Covered Services rendered have been ordered by your Primary Care Physician or Woman's Principal Health Care Provider.

Inpatient Benefits

There are no limits on the number of days available to you for Inpatient care in a Hospital or other eligible facility.

Benefits for Inpatient Chemical Dependency Treatment will be paid at 100% of the Provider's Charge.

Outpatient Benefits

Benefits for Outpatient office visits for Chemical Dependency Treatment are subject to a $20 Copayment per visit and then will be paid at 100% of the Provider's Charge.

However, benefits for Outpatient Chemical Dependency Treatment visits to a Specialist Physician's office are subject to a Copayment of $20 per visit and then will be paid in full.

Detoxification

Covered Services received for detoxification are not subject to the Chemical Dependency Treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS sections of this Certificate, as for any other condition.

AWAY FROM HOME CARE® BENEFITS

The Plan is a participant in a nation-wide network of Blue Cross and Blue Shield-affiliated plans. This enables the Plan to provide you with Guest Membership benefits when you are outside the service-area of the Plan.

GUEST MEMBERSHIP

If you will be living outside of the Home Plan's service area for more than 90 days, but will maintain a permanent residence within the Plan's service area, the Home Plan will establish a Guest Membership for you with a Host Plan serving the area in which you will be staying.

Under this arrangement, the Plan is referred to as the "**Home Plan**". The Blue Cross and Blue Shield plan in the area in which you are temporarily residing is called the "**Host Plan**".

This would apply for members who are:

1. On an extended work assignment in another state for a period of 90 days to six months;
2. Long-term travelers who will be out of the Home Plan's service area for 90 days to six months;
3. Eligible children at school out-of-state for periods of 90 days to one year; or
4. Eligible dependents living away from the employee's household in another state for periods of 90 days to one year.

Guest memberships for eligible children who are at school out-of-state or for eligible dependents who live in another state may be renewed at the end of the period.

You will select a Primary Care Physician in your Guest Membership's area, just as you have within your home area. This Primary Care Physician will be responsible for coordinating all of your health care needs.

You may contact your Employer or Group Administrator to initiate the establishment of a Guest Membership, or you may call Member Services directly at 1-800-892-2803.

Benefits for Guest Membership

Each Host Plan establishes its own Guest Membership benefits. Consequently, your Guest Membership Copayment may differ from your Home Plan Copayments. However, all Basic Services will be covered. The Host Plan will provide you with an explanation of your benefits and Copayments.

HUMAN ORGAN TRANSPLANT BENEFITS

Your coverage includes benefits for human organ and tissue transplants when ordered by your Primary Care Physician or Woman's Principal Health Care Provider and when performed at a Plan approved center for human organ transplants. To be eligible for benefits, your Primary Care Physician or Woman's Principal Health Care Provider must contact the office of the Plan's Medical Director prior to scheduling the transplant Surgery.

All of the benefits specified in the other benefit sections of this Certificate are available for Surgery performed to transplant an organ or tissue. In addition, benefits will be provided for transportation of the donor organ to the location of the transplant Surgery, limited to transportation in the United States or Canada. Benefits will also be available for donor screening and identification costs, under approved matched unrelated donor programs. Payment for Covered Services received will be the same as that specified in those benefit sections.

Benefits will be provided for both the recipient of the organ or tissue and the donor subject to the following rules:

— If both the donor and recipient have coverage with the Plan, each will have his/her benefits paid by his or her own program.

— If you are the recipient and your donor does not have coverage from any other source, the benefits of this Certificate will be provided for both you and your donor. The benefits provided for your donor will be charged against your coverage under this Certificate.

— If you are the donor and coverage is not available to you from any other source, the benefits of this Certificate will be provided for you. However, benefits will not be provided for the recipient.

Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Primary Care Physician or Woman's Principal Health Care Provider, and you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this Certificate, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

— Benefits for transportation and lodging are limited to a combined maximum of $10,000 per transplant. The maximum amount that will be provided for lodging is $50 per person per day.

In addition to the other exclusions of this Certificate, benefits will not be provided for the following:

1. Organ transplants, and/or services or supplies rendered in connection with an organ transplant, which are Investigational as determined by the appropriate technological body.
2. Drugs which are Investigational
3. Storage fees

4. Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
5. Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
6. Travel time or related expenses incurred by a Provider.
7. Meals

HOSPICE CARE BENEFITS

Your coverage includes benefits for services received in a Hospice Care Program. For benefits to be available for these services, they must have been ordered by your Primary Care Physician or Woman's Principal Health Care Provider.

In addition, they must be rendered by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less as certified by your Primary Care Physician or Woman's Principal Health Care Provider; and you will no longer benefit from standard medical care, or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care Program;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services – Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Services.

The following services are **not** covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including but not limited, to Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this Certificate.

Benefits are subject to the same payment provisions and day limitations specified in the Hospital Benefits and Physician Benefits Sections of this Certificate, depending upon the particular Provider involved (Hospital, Skilled Nursing Facility, Coordinated Home Care Program or Physician).

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and supplies which are self-administered. This section of your Certificate explains which drugs and supplies are covered and the benefits that are available for them. Benefits will be provided only if such drugs and supplies are Medically Necessary.

PRIOR AUTHORIZATION REQUIREMENT

When certain medications and drug classes are prescribed, your Physician will be required to obtain authorization from the Plan in order to receive benefits.

Your Physician must send a letter to the Plan's prescription drug administrator explaining the reason for the prescription. The prescription drug administrator will review the letter and determine whether the reason for the prescription meets the criteria for medically necessary care. You and your Physician will be notified of the prescription drug administrator's determination within twenty-four (24) hours. No benefits will be provided for such drugs if prior authorization is not received.

You should refer to the formulary list, contact your Pharmacy or refer to the Blue Cross and Blue Shield website to determine which medications and drug classes require prior authorization.

COVERED SERVICES

The drugs and supplies for which benefits are available under this Benefit Section are:

- drugs which are self-administered that require, by federal law, a written prescription;
- injectable insulin and insulin syringes;
- diabetic supplies, as follows: test strips, glucagon emergency kits and lancets.

Benefits for self-injectable drugs are limited to:

- insulin;
- drugs prescribed for the treatment of Infertility, or
- drugs prescribed for a particular condition for which they have been specifically approved by the Food and Drug Administration.

Benefits for these drugs will be provided when:

- you have been given a written prescription for them by your Physician, Dentist, Optometrist or Podiatrist;

- you purchase the drugs from a Pharmacy or from a Physician, Dentist, Optometrist or Podiatrist who regularly dispenses drugs, and
- the drugs are self-administered.

Benefits will not be provided for:

- drugs used for cosmetic purposes;
- any devices or appliances except as specifically mentioned above;
- any charges that you may incur for the drugs being administered to you;
- drugs for which there is an over-the-counter product available with the same active ingredient(s);
- drugs which are not self-administered;

In addition, benefits will not be provided for any prescription or refill dispensed after one year from the date of the prescription.

One prescription means up to a 34 consecutive day supply for most medications. Certain drugs may be limited to less than a 34 consecutive day supply. However, for certain maintenance type drugs, larger quantities may be obtained through the 90-day supply prescription drug program. Specific information on these maintenance drugs can be obtained from a Prescription Drug Provider participating in the 90-day supply prescription drug program or the Plan. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

34-DAY SUPPLY PRESCRIPTION DRUG PROGRAM

Benefit payment for the 34-day supply prescription drug program

The benefits you receive for drugs will differ depending upon whether you purchase a generic Drug, Formulary brand-name Drug or a non-Formulary brand-name Drug, whether or not the drug is purchased from a Participating Prescription Drug Provider, and whether or not the drug is self-injectable.

When you purchase drugs from a Participating Prescription Drug Provider, you will not be charged any amount other than the specified Copayment amount. The Copayment amount differs for generic Drugs, Formulary brand-name Drugs, non-Formulary brand-name Drugs, and Self-Injectable Drugs. The Copayment amounts are shown in the Benefit Highlights section of this Certificate. You will be charged the Copayment amount for each prescription. There is no charge to you for diabetic supplies.

No benefits will be provided for drugs purchased from a Non-Participating Prescription Drug Provider in Illinois. However, if the Non-Participating Prescription Drug Provider is located outside of Illinois, then benefits for drugs purchased for emergency conditions will be provided at 100% of the amount that would have been paid had you purchased such drugs from a Participating Prescription Drug Provider, minus the Copayment amount.

90-DAY SUPPLY PRESCRIPTION DRUG PROGRAM

Benefit payment for the 90-day supply prescription drug program

In addition to the benefits described in this Benefit Section, your coverage includes benefits for maintenance type drugs obtained from a Prescription Drug Provider (which may include retail or mail order pharmacies) participating in the 90-day supply prescription drug program. You will not be charged any amount other than the specified Copayment amount. The Copayment amounts are shown in the Benefit Highlights section of this Certificate. There is no charge to you for diabetic supplies.

Benefits will not be provided for 90-day supply drugs purchased from a Prescription Drug Provider not participating in the 90-day supply program.

You can obtain an order form for the 90-day supply prescription drug program from your Group or from the Plan.

PRE-ADMISSION CERTIFICATION AND CONCURRENT REVIEW

Pre-Admission Certification and Concurrent Review are two programs that have been established to ensure that you receive the most appropriate and cost effective health care.

PRE-ADMISSION CERTIFICATION

Pre-Admission Certification applies when you need to be admitted to a Hospital as an Inpatient in other than an emergency situation. Prior to your admission, your Primary Care Physician or Woman's Principal Health Care Provider must obtain approval of your admission from the Participating IPA/Participating Medical Group with which he/she is affiliated or employed. The Participating IPA/Participating Medical Group may recommend other courses of treatment that could help you avoid an Inpatient stay. It is your responsibility to cooperate with any recommendations made by the Participating IPA/Participating Medical Group.

CONCURRENT REVIEW

Once you have been admitted to a Hospital as an Inpatient, your length of stay will be reviewed by the Participating IPA/Participating Medical Group. The purpose of that review is to ensure that your length of stay is appropriate given your diagnosis and the treatment that you are receiving. This is known as Concurrent Review.

If your Hospital stay is longer than the usual length of stay for your type of condition, the Participating IPA/Participating Medical Group will contact your Primary Care Physician or Woman's Principal Health Care Provider to determine whether there is a medically necessary reason for you to remain in the Hospital. Should it be determined that your continued stay in the Hospital is not medically necessary, you will be informed of that decision, in writing, and of the date that your benefits for that stay will end.

EXCLUSIONS — WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— Services or supplies that are not specifically stated in this Certificate.

— Services or supplies that were not ordered by your Primary Care Physician or Woman's Principal Health Care Provider except as explained in the EMERGENCY CARE BENEFITS section, CHEMICAL DEPENDENCY TREATMENT BENEFITS section, HOSPITAL BENEFITS section and, for Mental Illness (other than Serious Mental Illness) or routine vision examinations, in the PHYSICIAN BENEFITS section of this Certificate.

— Services or supplies that were received prior to the date your coverage began or after the date that your coverage was terminated.

— Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any business or enterprise, defined as a "small business" under paragraph (b), Section 3 or the Illinois Small Business Purchasing Act, as amended, and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

— Services or supplies that are furnished to you by the local, state or federal government and services or supplies to the extent payments or benefits for such services or supplies are provided by or available from the local, state or federal government (for example, Medicare) whether or not those payments or benefits are received, except, however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI, or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 § 1-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

— Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that the Plan has provided benefits for the services or supplies rendered in connection with such injury.

— Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are Investigational in nature, except as specifically provided for in this Certificate.

— Custodial Care Service.

— Long Term Care Services.

— Respite Care Services, except as specifically mentioned under Hospice Care Benefits.

— Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury

resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

— Special education therapy such as music therapy or recreational therapy, except as specifically provided for in this Certificate.

— Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, tumors or disease.

— Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.

— Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form or charges for the transfer of medical records.

— Personal hygiene, comfort or convenience items commonly used for other than medical purposes such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

— Special braces, splints, specialized equipment, appliances, ambulatory apparatus or, battery implants except as specifically stated in this Certificate.

— Prosthetic devices, special appliances or surgical implants which are for cosmetic purposes, the comfort or convenience of the patient or unrelated to the treatment of a disease or injury.

— Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins and herbal supplements.

— Blood derivatives which are not classified as drugs in the official formularies.

— Marriage counseling.

— Hypnotism.

— Inpatient and Outpatient Private Duty Nursing Service.

— Routine foot care, except for persons diagnosed with diabetes.

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Certificate.

— Maintenance Care.

— Self-management training, education and medical nutrition therapy, except as specifically stated in this Certificate.

— Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth except as specifically stated in this Certificate.

— Repair or replacement of appliances and/or devices due to misuse or loss, except as specifically mentioned in this Certificate.

— Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.

— Services or supplies rendered for human organ or tissue transplants except as specifically provided for in this Certificate.

— Wigs (also referred to as cranial prostheses).

— Services or supplies rendered for infertility treatment except as specifically provided for in this Certificate.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies to this Benefit Program when you or your covered dependent has health care coverage under more than one Benefit Program. COB does not apply to the Outpatient Prescription Drug Program Benefits.

The order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Benefit Program are determined before or after those of another Benefit Program. The benefits of this Benefit Program:

1. Shall not be reduced when, under the order of benefit determination rules, this Benefit Program determines its benefits before another Benefit Program; but
2. May be reduced when, under the order of benefits determination rules, another Benefit Program determines its benefits first. This reduction is described below in "When this Benefit Program is a Secondary Program."

In addition to the Definitions Section of this Certificate, the following definitions apply to this section:

ALLOWABLE EXPENSE.....means a Covered Service, when the Covered Service is covered at least in part by one or more Benefit Program covering the person for whom the claim is made.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless your stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Benefit Program.

When a Benefit Program provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

BENEFIT PROGRAM.....means any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(i) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.

(ii) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the Social Security Act).

Each contract or other arrangement under (i) or (ii) above is a separate benefit program. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate program.

CLAIM DETERMINATION PERIOD.....means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Benefit Program, or any part of a year before the date this COB provision or a similar provision takes effect.

PRIMARY PROGRAM or SECONDARY PROGRAM.....means the order of payment responsibility as determined by the order of benefit determination rules.

When this Benefit Program is the Primary Program, its benefits are determined before those of the other Benefit Program and without considering the other program's benefits.

When this Benefit Program is a Secondary Program, its benefits are determined after those of the other Benefit Program and may be reduced because of the other program's benefits.

When there are more than two Benefit Programs covering the person, this Benefit Program may be a Primary Program as to one or more other programs, and may be a Secondary Program as to a different program or programs.

ORDER OF BENEFIT DETERMINATION

When there is a basis for a Claim under this Benefit Program and another Benefit Program, this Benefit Program is a Secondary Program which has its benefits determined after those of the other program, unless:

1. The other Benefit Program has rules coordinating its benefits with those of this Benefit Program; and
2. Both those rules and this Benefit Program's rules, described below, require that this Benefit Program's benefits be determined before those of the other Benefit Program.

This Benefit Program determines its order of benefit payments using the first of the following rules which applies:

1. Non-Dependent or Dependent

   The benefits of the Benefit Program which covers the person as an employee, member or subscriber (that is, other than a dependent) are determined before those of the Benefit Program which covers the person as dependent; except that, if the person is also a Medicare beneficiary, Medicare is:

   a. Secondary to the Benefit Program covering the person as a dependent; and
   b. Primary to the Benefit Program covering the person as other than a dependent, for example a retired employee.

2. Dependent Child if Parents not Separated or Divorced

   Except as stated in rule 3 below, when this Benefit Program and another Benefit Program cover the same child as a dependent of different persons, called "parents:"

   a. The benefits of the program of the parent whose birthday (month and day) falls earlier in a calendar year are determined before those of the program of the parent whose birthday falls later in that year; but

b. If both parents have the same birthday, the benefits of the program which covered the parents longer are determined before those of the program which covered the other parent for a shorter period of time.

However, if the other Benefit Program does not have this birthday-type rule, but instead has a rule based upon gender of the parent, and if, as a result, the Benefit Programs do not agree on the order of benefits, the rule in the other Benefit Program will determine the order of benefits.

3. Dependent Child if Parents Separated or Divorced

If two or more Benefit Programs cover a person as a dependent child of divorced or separate parents, benefits for the child are determined in this order:

a. First, the program of the parent with custody of the child;

b. Then, the program of the spouse of the parent with the custody of the child; and

c. Finally, the program of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the program of that parent has actual knowledge of those terms, the benefits of that program are determined first. The program of the other parent shall be the Secondary Program. This paragraph does not apply with respect to any Claim Determination Period or Benefit Program year during which any benefits are actually paid or provided before the entity has that actual knowledge. It is the obligation of the person claiming benefits to notify the Plan and, upon its request, to provide a copy of the court decree.

4. Dependent Child if Parents Share Joint Custody

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Benefit Programs covering the child shall follow the order of benefit determination rules outlined in 2 above.

5. Active or Inactive Employee

The benefits of a Benefit Program which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Benefit Program which covered that person as a laid off or retired employee (or as that employee's dependent). If the other Benefit Program does not have this rule, and if, as a result, the Benefit Programs do not agree on the order of benefits, this rule is ignored.

6. Continuation Coverage

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

a. First, the benefits of a Benefit Program covering the person as an employee, member or subscriber (or as that person's dependent);

b. Second, the benefits under the continuation coverage.

If the other Benefit Program does not contain the order of benefits determination described within this rule, and if, as a result, the programs do not agree on the order of benefits, this requirement shall be ignored.

7. Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the Benefit Program which covered an employee, member or subscriber longer are determined before those of the Benefit Program which covered that person for the shorter term.

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

In the event this Benefit Program is a Secondary Program as to one or more other Benefit Programs, the benefits of this Benefit Program may be reduced.

The benefits of this Benefit Program will be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expenses under this Benefit Program in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Benefit Programs, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made;

Exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Benefit Program will be reduced so that they and the benefits payable under the other Benefit Programs do not total more than those Allowable Expenses.

When the benefits of this Benefit Program are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Benefit Program.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Benefit Program must give the Plan any facts it needs to pay the Claim.

FACILITY OF PAYMENT

A payment made under another Benefit Program may include an amount which should have been paid under this Benefit Program. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Benefit Program. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

REDUCTION IN BENEFITS

The amount by which your benefits under this Benefit Program have been reduced is called your ''savings.'' Savings can be used to pay for services that are not covered under this Benefit Program provided that the services are covered under another Benefit Program and were not completely paid for under that Benefit Program. Savings can only be used to pay for services rendered in the same calendar year in which the Claim that earned the savings is actually processed.

In order to have Claims paid from your savings, a Claim for such payment, including a statement of savings earned, must be submitted to the Plan no later than March 31st of the calendar year immediately following the calendar year in which the savings were earned.

HOW TO FILE A CLAIM

When you receive care from your Primary Care Physician or from another Provider who is affiliated with your Participating IPA/Participating Medical Group, or from your Woman's Principal Health Care Provider, a Claim for benefits does not have to be filed with the Plan. All you have to do is show your Plan ID card to your Provider. However, to receive benefits for care from another Physician or Provider, you must be referred to that Provider by your Primary Care Physician or Woman's Principal Health Care Provider.

When you receive care from Providers outside of your Participating IPA/Participating Medical Group (i.e. emergency care, medical supplies), usually all you have to do to receive your benefits under this Certificate is to, again, show your Plan ID card to the Provider. Any Claim filing required will be done by the Provider.

There may be situations when you have to file a Claim yourself (for example, if a Provider will not file one for you). To do so, send the following to the Plan:

1. an itemized bill from the Hospital, Physician or other Provider (including the Provider's name and address, the patient's name, the diagnosis, the date of service, a description of the service and the Claim Charge);
2. the Eligible Person's name and Plan ID number;
3. the patient's name, age and sex;
4. any additional relevant information.

Mail all of that information to:

Blue Cross and Blue Shield
300 East Randolph Street
Chicago, Illinois 60601-5099

In any case, it is your responsibility to make sure that the necessary Claim information has been provided to the Plan. Claims must be filed no later than December 31st of the calendar year following the year in which the Covered Service was rendered. For the purposes of this filing time limit, Covered Services rendered in December will be considered to have been rendered in the next calendar year.

If you have any questions about a Claim, call **Member Services at 1-800-892-2803.**

FILING OUTPATIENT PRESCRIPTION DRUG PROGRAM CLAIMS

In certain situations, you will have to file your own Claims in order to obtain benefits under the Outpatient Prescription Drug Program. This is primarily true when you did not receive an identification card, the pharmacy was unable to transmit a claim or you received benefits from a non-Participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete an Outpatient Prescription Drug Program Claim Form. These forms are available from your Employee Benefits Department or from the Plan.
2. Attach copies of all pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

   Blue Cross and Blue Shield of Illinois
   P. O. Box 64812
   St. Paul, MN 55164-0812

In any case, Claims must be filed no later than one year after the date a service is received. Claims not filed within one year from the date a service is received, will not be eligible for payment.

CLAIM PROCEDURES

The Plan will pay all Claims within 30 days of receipt of all information required to process a Claim. In the event that the Plan does not process a Claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Plan will notify you or the valid assignee when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provision in the OTHER THINGS YOU SHOULD KNOW section of this Certificate.)

If the Claim is denied in whole or in part, you will receive a notice from the Plan with: (1) the reasons for denial; (2) a reference to the health care plan provisions on which the denial is based; (3) a description of additional information which may be necessary to perfect the appeal, and (4) an explanation of how you may have the Claim reviewed by the Plan if you do not agree with the denial.

CLAIM REVIEW PROCEDURES

If your Claim has been denied in whole or in part, you may have your Claim reviewed. The Plan will review its decision in accordance with the following procedure.

Within 180 days after you receive notice of a denial or partial denial, write or telephone the Plan. You will need to submit the reason why you do not agree with the denial or partial denial, comments and any additional medical information. Send your request to or contact:

Claim Review Section
Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, Illinois 60680-4112
1-800-892-2803

You may also designate a representative to act for you during the review process. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

The Plan will give you a written decision within 60 days after it receives your request for review. Upon completion of the review, you and your authorized representative may ask to see relevant documents used during the review process.

If you have any questions about the Claims procedures or the review process, write or call the Plan between the hours of 8:45 A.M. to 4:45 P.M., Monday through Friday.

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, IL 60680-4112
1-800-892-2803

INQUIRIES AND COMPLAINTS

An **"Inquiry"** is a general request for information regarding claims, benefits, or membership.

A **"Complaint"** is an expression of dissatisfaction by you either orally or in writing.

The Plan has a team of professionals available to assist you with inquiries and complaints. Issues may include, but are not limited to, the following:

- Claims
- Referrals to a Specialist
- Changing your Participating IPA or Participating Medical Group
- Quality of Care

You may contact **Member Services at 1-800-892-2803**, or you may write to:

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, Illinois 60680-4112

When you contact Member Services, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your case within 30 days of receipt by Member Services. If the Plan needs more information, you will be contacted. If a decision will be delayed due to the need for additional information, you will be contacted.

APPEALS

If you submit an inquiry or complaint and it is not resolved to your satisfaction, you may appeal the decision.

An appeal is an oral or written request for a review of an adverse decision or action by the Plan, its employees, or the Participating Medical Group/IPA. An appeal may be filed by you, a person designated to act on your behalf, your Pri-

mary Care Physician or Woman's Principal Health Care Provider or any health care provider.

No person reviewing the appeal may have been involved in the initial determination that is the subject of the appeal.

If an appeal is not resolved to your satisfaction, you may appeal the Plan's decision to the Illinois Department of Financial and Professional Regulation - Division of Insurance. The Division of Insurance will notify the Plan of the appeal. The Plan will have 21 days to respond to the Division of Insurance.

URGENT/EXPEDITED CLINICAL APPEALS

Upon receipt of an Urgent/Expedited pre-service or concurrent Clinical Appeal, the Plan will notify the party filing the appeal, MG/IPA or Primary Care Physician (PCP) as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Plan shall render a determination on the appeal within 24 hours after it receives the requested information.

CLINICAL APPEALS

Upon receipt of a non-urgent pre-service or post-service Clinical Appeal, the Plan will notify the party filing the appeal within three business days if additional information is needed to review the appeal. Additional information must be submitted within five calendar days of request. The Plan shall render a determination on the appeal within 15 business days after it receives the requested information.

NOTIFICATION

The Plan will notify the party filing the appeal, you, your Primary Care Physician or Woman's Principal Health Care Provider, and any health care provider who recommended the services involved in the appeal orally of its determination followed-up by a written notice of the determination.

The written notification will include:

- A clear and detailed reason for the determination.
- Medical or clinical criteria used in the determination.
- Procedures for requesting an external independent review, if your appeal is denied. An external independent reviewer shall be a clinical peer, have no direct financial interest in connection with the review and will not know your identity.

EXPEDITED EXTERNAL INDEPENDENT REVIEW

An expedited external independent review can be requested when a delay would significantly increase the risk to your health or when extended health care services, ordered by a health care provider for an Ongoing Course of Treatment, are at issue.

The external independent reviewer shall make a determination and provide notice of the determination within 24 hours of receiving all necessary information needed to review the case.

EXTERNAL INDEPENDENT REVIEW

You must submit a written request for a review within 30 days of receiving a denial of a Clinical Appeal. Any information or documentation to support your request for the health care services must be included.

Within 30 days of receipt of your request, the Plan will:

- select an external independent reviewer that is acceptable to you, your Primary Care Physician or Woman's Principal Health Care Provider, or other health care provider; and
- forward to the external independent reviewer all medical records and supporting documentation, a description of the issues including a statement of the Plan's decision, the criteria used and the medical and clinical reasons for the decision.

Within 5 days after receipt of the necessary information, the external independent reviewer will render a decision based on whether or not the health care services being appealed were medically appropriate and you will receive notification from the Plan. The decision of the external independent reviewer is final. If you disagree with the determination of the external independent reviewer, you may contact the Illinois Division of Insurance.

Benefits will not be provided for services or supplies not covered under your Certificate even if the external independent reviewer determines that the health care services being appealed were medically appropriate.

NON-CLINICAL APPEALS

Upon receipt of a pre-service or post-service Non-Clinical Appeal, the Plan will notify the party filing the appeal within three business days if additional information is needed to review the appeal. Additional information must be submitted within five calendar days of request. The Plan shall render a decision on the appeal within 15 business days after it receives the requested information.

NOTIFICATION

The Plan will notify you and the party filing the Non-Clinical Appeal orally of its determination, followed-up by a written notice of determination.

The written notification will include:

- A clear and detailed reason for the determination.
- Contractual, administrative or protocol for the determination.

Filing an appeal does not prevent you from filing a complaint with the Illinois Department of Financial and Professional Regulation - Division of Insurance or keep the Division of Insurance from investigating a complaint. The Division of Insurance can be contacted at the following addresses:

Illinois Department of Financial and
Professional Regulation, Division of Insurance
Consumer Division
100 West Randolph Street
Suite 15-100
Chicago, Illinois 60601

or

Illinois Department of Financial and
Professional Regulation, Division of Insurance
Consumer Division
320 West Washington Street
Springfield, Illinois 62767

In addition, if you have an adverse appeal determination, you may file civil action in a state or federal court.

OTHER THINGS YOU SHOULD KNOW

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits have been provided for Covered Services described in this Policy, you agree:

a. the Plan has the right to reimbursement for all benefits the Plan provided from any and all damages collected from the third party for those same expenses, whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury:

   (i) in the case of health care facilities and certain contracted Providers, the calculation of any lien shall be based on the amount the Plan charges the group's experience for Covered Services rendered to you; and

   (ii) in the case of Providers other than health care facilities, the calculation of any lien shall be based on the Plan's benefit payment for Covered Services rendered to you.

b. the Plan is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Plan provided for that sickness or injury. The Plan shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses the Plan has provided as a result of that sickness or injury.

For the purposes of this provision, the cost of benefits provided will be the charges that would have been billed if you had not been enrolled under this benefit program.

You are required to furnish any information or assistance and to provide any documents that the Plan may request in order to obtain its rights under this provision.

PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Plan has contracts with certain Providers and other suppliers of goods and services for the provision of and/or payment for health care goods and services to all persons entitled to health care benefits under individual and group policies or contracts to which the Plan is a party, including all persons covered under your Group's Policy.

Under certain circumstances described in its contracts with such Providers and suppliers, the Plan may:

— receive substantial payments from Providers or suppliers with respect to goods, supplies and services furnished to all such persons for which the Plan was obligated to pay the Provider or supplier, or

— pay Providers or suppliers substantially less than their Claim Charges for goods or services, by discount or otherwise, or

— receive from Providers or suppliers other substantial allowances under the Plan's contracts with them.

Your Group understands that the Plan may receive such payments, discounts, and/or other allowances during the term of the Policy.

Neither you nor your Group are entitled to receive any portion of any such payments, discounts, and/or other allowances. Any Copayments and/or deductibles payable by you are pre-determined fixed amounts, based upon the selected benefit plan, which are not impacted by any discounts or contractual allowances which the Plan may receive from a Provider.

OTHER BLUE CROSS AND BLUE SHIELD PLANS' SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

BlueCard

The Plan hereby informs you that other Blue Cross and Blue Shield Plans outside of Illinois ("Host Blue") may have contracts similar to the contracts described above with certain Providers ("Host Blue Providers") in their service area.

Under BlueCard, when you receive health care services outside of Illinois and from a Provider which does not have a contract with the Plan, the amount you pay, if not covered by a flat dollar Copayment, for Covered Services is calculated on the lower of:

— The billed charges for your Covered Services, or

— The negotiated price that the Host Blue passes on to the Plan.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increases or reductions to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this provision or require a surcharge, the Plan would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

PLAN'S SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS

Plan's Separate Financial Arrangements with Prescription Drug Providers

The Plan hereby informs you that it has contracts, either directly or indirectly, with prescription drug providers ("Participating Prescription Drug Providers") to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which the Plan is a party, including all persons covered under this Certificate. Under its contracts with Participating Prescription Drug Providers, the Plan may receive from these providers discounts for prescription drugs dispensed to you. Neither the Group nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

Plan's Separate Financial Arrangements with Pharmacy Benefit Managers

The Plan owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Plan has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on the Plan's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Plan. Neither the Group nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

All benefit payments may be made by the Plan directly to any Provider furnishing the Covered Services for which such payment is due, and the Plan is authorized by you to make such payments directly to such Providers. However, the Plan reserves the right to pay any benefits that are payable under the terms of this Certificate directly to you.

You will not receive any notices regarding Covered Services received from your Primary Care Physician (or other Providers who are part of your Participating IPA/Participating Medical Group) because Claims do not have to be filed for those services.

Once Covered Services are rendered by a Provider, you have no right to request that the Plan not pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Plan will have no liability to you or any other person because of its rejection of such request.

Neither this Certificate nor a covered person's Claim for payment of benefits under this Certificate is assignable in whole or in part to any person or entity at any time. Coverage under this Certificate is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage.

COVERED SERVICES EXPENSE LIMITATION

If, during any contract year, you have paid Copayments and/or deductibles for Covered Services under this Certificate the total amount of which equals $1,500

per enrollee or $3,000 per family, your benefits for any additional Covered Services that you may receive during that contract year, including any Copayment or deductible amounts, will be reimbursed by the Plan.

In the event your physician or the hospital requires you to pay any additional Copayments or deductible amounts after you have met the above provision, upon receipt of properly authenticated documentation, the Plan will reimburse to you, the amount of those Copayments and/or deductibles.

Copayments and deductibles required under this Certificate are not to exceed 50% of the usual and customary fee for any single service.

The above Covered Services expense provisions are not applicable to the benefits described in the following sections of this Certificate: Supplemental Benefits; Outpatient Prescription Drug Program Benefits.

YOUR PROVIDER RELATIONSHIPS

The choice of a Hospital, Participating IPA, Participating Medical Group, Primary Care Physician or any other Provider is solely your choice and the Plan will not interfere with your relationship with any Provider.

The Plan does not itself undertake to provide health care services, but solely to arrange for the provision of health care services and to make payments to Providers for the Covered Services received by you. The Plan is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Plan. Any contractual relationship between a Physician and a Hospital or other Provider should not be construed to mean that the Plan is providing professional service.

Each Provider provides Covered Services only to Covered Persons and does not deal with or provide any services to any Group (other than as an individual Covered Person) or any Group's ERISA Health Benefit Program.

FAILURE OF YOUR PARTICIPATING IPA OR PARTICIPATING MEDICAL GROUP TO PERFORM UNDER ITS CONTRACT

Should your Participating IPA or Participating Medical Group fail to perform under the terms of its contract with the Plan, as determined by the Plan, or fail to renew such contract, the benefits of this Certificate will be provided for you for Covered Services received from other Providers limited to Covered Services received during a thirty day period beginning on the date of the Participating IPA's/Participating Medical Group's failure to perform or failure to renew its contract with the Plan. During this thirty day period, you will have the choice of transferring your enrollment to another Participating IPA or Participating Medical Group or of transferring your coverage to any other health care coverage then being offered by your Group to its members. Your transferred enrollment or coverage will be effective thirty-one days from the date your Participating IPA or Participating Medical Group failed to perform or failed to renew its contract with the Plan.

ENTIRE POLICY

The Group Policy, including the Certificate, any Addenda and/or Riders, the Benefit Program Application of the Group for the Policy and the individual applications, if any, of the Enrollees constitutes the entire contract of coverage between the Group and the Plan.

AGENCY RELATIONSHIPS

Your Group is your agent under this Certificate. Your Group is not the agent of the Plan.

NOTICES

Any information or notice which you furnish to the Plan under this Certificate must be in writing and sent to the Plan at its offices at 300 East Randolph Street, Chicago, Illinois, 60601-5099 (unless another address has been stated in this Certificate for a specific situation). Any information or notice which the Plan furnishes to you must be in writing and sent to you at your address as it appears on the Plan's records or in care of your Group and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Plan's records.

LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Certificate until at least 60 days have elapsed since a Claim has been furnished to the Plan in accordance with the requirements of this Certificate. In addition, no such action may be brought once 3 years have elapsed from the date that a Claim is required to be furnished to the Plan in accordance with the requirements of this Certificate.

INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under this Certificate, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnification on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Plan or its agent, and agrees that any such Provider, person, or other entity may furnish to the Plan or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Plan may furnish similar information and records (or copies of records) to Providers, other Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs, or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the Plan and/or your employer or group administrator information regarding you or your dependents becoming eligible for Medicare, termination of Medicare eligibility, or any change in Medicare eligibility status, in order that the Plan be able to make Claim Payments in accordance with MSP laws.

DEFINITIONS

Throughout this Certificate, many words are used which have a specific meaning when applied to your health care coverage. The definitions of these words are listed below in alphabetical order. **These defined words will always be capitalized when used in this Certificate.**

Ambulatory Surgical Facility .....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

Behavioral Health Practitioner .....means a Physician or professional Provider who is duly licensed to render services for the treatment of Mental Illness, Serious Mental Illness or Chemical Dependency Treatment.

Certificate .....means this booklet and your application for coverage under the Plan benefit program described in this booklet.

Certificate of Creditable Coverage .....means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program for purposes of reducing any preexisting condition exclusion imposed by any group health plan coverage.

Certified Clinical Nurse Specialist .....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of an advanced practice nursing program.

Certified Nurse Midwife .....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

Certified Nurse Practitioner .....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of an advanced practice nursing program.

Certified Registered Nurse Anesthetist (CRNA) .....means a person who (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

Chemical Dependency .....means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner.

Chemical Dependency Treatment .....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Chemical Dependency Treatment Facility. It does not include programs consisting primarily of counseling by individuals (other than a Behavioral Health Practitioner), court-ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

Chemical Dependency Treatment Facility .....means a facility (other than a Hospital) whose primary function is the treatment of Chemical Dependency and which is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

Chemotherapy .....means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

Chiropractor .....means a duly licensed chiropractor.

Claim .....means notification in a form acceptable to the Plan that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which the Plan may request in connection with services rendered to you.

Claim Charge ……means the amount which appears on a Claim as the Provider's or supplier's charge for goods or services furnished to you, without adjustment or reduction and regardless of any separate financial arrangement between the Plan and a particular Provider or supplier. (See provisions of this Certificate regarding "Plan's Separate Financial Arrangements with Providers.")

Claim Payment ……means the benefit payment calculated by the Plan, after submission of a Claim, in accordance with the benefits described in this Certificate. All Claim Payments will be calculated on the basis of the Provider's Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Plan and a particular Provider. (See provisions of this Certificate regarding "Plan's Separate Financial Arrangements with Providers.")

Clinical Appeal ……means an appeal related to health care services, including, but not limited to, procedures or treatments ordered by a health care provider that do not meet the definition of an Urgent/Expedited Clinical Appeal.

COBRA ……means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 P.L. 99-272, as amended which regulate the conditions and manner under which an employer can offer continuation of group health insurance to employees and their family members whose coverage would otherwise terminate under the terms of this Certificate.

Continuous Ambulatory Peritoneal Dialysis Treatment ……means a continuous dialysis process using a patient's peritoneal membrane as a dialyzer.

Coordinated Home Care Program ……means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.)

Copayment ……means a specified dollar amount that you are required to pay towards a Covered Service.

Coverage Date ……means the date on which your coverage under this Certificate begins.

Covered Service ……means a service or supply specified in this Certificate for which benefits will be provided.

Creditable Coverage ……means coverage you had under any of the following:

a) A group health plan.

b) Health insurance coverage for medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

c) Medicare (Parts A or B of Title XVIII of the Social Security Act).

d) Medicaid (Title XIX of the Social Security Act).

e) Medical care for members and certain former members of the uniformed services and their dependents.

f) A medical care program of the Indian Health Service or of a tribal organization.

g) A State health benefits risk pool.

h) A health plan offered under the Federal Employees Health Benefits Program.

i) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government or a foreign country.

j) A health benefit plan under section 5(e) of the Peace Corps Act.

k) State Children's Health Insurance Program (Title XXI of the Social Security Act).

Custodial Care Service ……means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills or professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications etc.) and are to assist with activities of daily living, (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

Dentist ……means a duly licensed dentist.

Diagnostic Service ……means tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury. Examples of these types of tests are x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

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

Electroconvulsive Therapy ……means a medical procedure in which a brief application of an electric stimulus is used to produce a generalized seizure.

Emergency Condition ……means an accidental bodily injury or a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

b) serious impairment to bodily functions; or

c) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

Enrollee ……means the person who has applied for coverage under this Certificate and to whom the Plan has issued an identification card.

Enrollment Date ……means the first day of coverage under your Group's health plan or, if your Group has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins).

Family Coverage ……means that your application for coverage was for yourself and other eligible members of your family.

Formulary Drug ……means a brand name prescription drug that has been designated as a preferred drug by the Plan. The listing of drugs designated as being Formulary Drugs may be amended from time to time by the Plan.

Hospice Care Program ……means a centrally administered program designed to provide physical, psychological, social and spiritual care for terminally ill persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program service is available in the home, or in Inpatient Hospital or Skilled Nursing Facility special hospice care unit.

Hospice Care Program Provider ……means an organization duly licensed to provide Hospice Care Program service.

Hospital ……means a facility which is a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled. It does not include health resorts, rest homes, nursing homes, custodial homes for the aged or similar institutions.

Individual Coverage ……means that your application for coverage was only for yourself.

Inpatient ……means that you are a registered bed patient and are treated as such in a health care facility.

Investigational ……means procedures, drugs, devices, services and/or supplies which (a) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (b) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to a covered person, and (c) specifically with respect to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to the covered person.

Long Term Care Services ……means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

Maintenance Care ……means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of a condition will occur.

Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapy ……means therapy administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of a condition will occur.

Marriage and Family Therapist ……means a duly licensed marriage and family therapist.

Medical Care ……means the ordinary and usual professional services rendered by a Physician, Behavioral Health Practitioner, or other specified Provider during a professional visit, for the treatment of an illness or injury.

Medicare ……means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

Medicare Secondary Payer or MSP ……means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

Mental Illness ……means those illnesses classified as mental disorders in the edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association which is current as of the date services are rendered to a patient.

"Serious Mental Illness".....means the following mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

(i) Schizophrenia;

(ii) Paranoid and other psychotic disorders;

(iii) Bipolar disorders (hypomanic, manic, depressive and mixed);

(iv) Major depressive disorders (single episode or recurrent);

(v) Schizoaffective disorders (bipolar or depressive);

(vi) Pervasive developmental disorders;

(vii) Obsessive-compulsive disorders;

(viii) Depression in childhood and adolescence;

(ix) Panic disorder;

(x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and

(xi) Anorexia nervosa and bulimia nervosa.

Non-Clinical Appeal …….means an appeal of non-clinical issues, such as appeals pertaining to benefits and administrative procedures.

Occupational Therapy ……means a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function.

Ongoing Course of Treatment ……means the treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a Physician because of the potential for changes in the therapeutic regimen.

Optometrist ……means a duly licensed optometrist.

Outpatient ……means that you are receiving treatment while not an Inpatient.

Partial Hospitalization Treatment Program ……means a Hospital's planned therapeutic treatment program, which has been approved by your Participating IPA or Participating Medical Group, in which patients with Mental Illness spend days or nights.

Participating IPA ……means any duly organized Individual Practice Association of Physicians which has a contract or agreement with the Plan to provide professional and ancillary services to persons enrolled under this benefit program.

Participating Medical Group ……means any duly organized group of Physicians which has a contract or agreement with the Plan to provide professional and ancillary services to persons enrolled under this benefit program.

Pharmacy ……means any licensed establishment in which the profession of pharmacy is practiced.

Physical Therapy ……means the treatment by physical means by or under the supervision of a qualified physical therapist.

Physician ……means a physician duly licensed to practice medicine in all of its branches.

Physician Assistant ……means a duly licensed physician assistant performing under the direct supervision of a Physician.

Plan ……Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association of which HMO Illinois is a product line.

Podiatrist ……means a duly licensed podiatrist.

Policy ……means the agreement between the Plan and the Group, including the Certificate, any addenda or riders that apply, the Benefit Program Application of the Group and the individual applications, if any, of the persons covered under the Policy.

Prescription Drug Provider ……means any Pharmacy which regularly dispenses drugs.

1. **Participating Prescription Drug Provider** …… means a Prescription Drug Provider which has entered into a written agreement with this Plan, or any entity designated by the Plan to administer its prescription drug program, to provide services to you at the time services are rendered to you and, for Pharmacies located in the state of Illinois, which has direct on-line computer access to the Plan or such administrative entity.

2. **Non-Participating Prescription Drug Provider** …… means a Prescription Drug Provider which does not meet the definition of a Participating Prescription Drug Provider.

Primary Care Physician (PCP) ……means a Provider who is a member or employee of or who is affiliated with or engaged by a Participating IPA or Participating Medical Group and who is a) a Physician who spends a majority of clinical time engaged in general practice or in the practice of internal medicine, pediatrics, gynecology, obstetrics, psychiatry or family practice, or b) a Chiropractor, and who you have selected to be primarily responsible for assessing, treating or coordinating your health care needs.

Private Duty Nursing Service ……means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse. Private Duty Nursing Service does not include Custodial Care Service.

Provider ……means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) duly licensed to render Covered Services to you.

Provider's Charge ……means a) in the case of your Primary Care Physician or another Physician who is affiliated with your Participating IPA/Participating Medical Group, the amount that such Physician would have charged for a good or service had you not been enrolled under this benefit program or b) in the case of a Provider or supplier which is not affiliated with your Participating IPA/Participating Medical Group, such Provider's or supplier's Claim Charge for Covered Services but not to exceed the reasonable charge therefor as reasonably determined by the Plan. For the purposes of subsection b), the reasonable charge shall be determined by taking into consideration the Provider's or supplier's usual charge to others for the same good or service, the range of usual charges of other Providers or suppliers in a similar geographic area for the same good or service under similar or comparable circumstances and any extenuating or unusual circumstances that are relevant to the charge in a particular case.

Psychologist ……means:

a) a Clinical Psychologist who is registered with the Illinois Department of Professional Regulation pursuant to the Illinois ''Psychologist Registration Act'' (111 Ill. Rev. Stat. §5301 et seq., as amended or substituted); or

b) in a state where statutory licensure exists, a Clinical Psychologist who holds a valid credential for such practice; or

c) if practicing in a state where statutory licensure does not exist, a psychologist who specializes in the evaluation and treatment of Mental Illness and Chemical Dependency and who meets the following qualifications:

   1. has a doctoral degree from a regionally accredited University, College or Professional School and has two years of supervised experience in

health services of which at least one year is postdoctoral and one year in an organized health services program; or

2. is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College and has not less than six years experience as a psychologist with at least two years of supervised experience in health services.

Radiation Therapy ……means the use of ionizing radiation in the treatment of a medical illness or condition.

Renal Dialysis Treatment ……means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

Residential Treatment Center ……means a facility setting offering therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision and structure. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Chemical Dependency disorders.

Respite Care Services ……means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services for you.

Serious Mental Illness ……See definition of Mental Illness.

Skilled Nursing Facility ……means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

Skilled Nursing Service ……means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skills and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

Specialist Physician ……means a Provider with a contractual relationship or affiliation with the Participating IPA/Participating Medical Group who does not meet the definition of a Primary Care Physician, Woman's Principal Health Care Provider, or Behavioral Health Practitioner.

Speech Therapy ……means treatment for the correction of a speech impairment, including pervasive developmental disorders.

Standing Referral ……means a written referral from your Primary Care Physician or Woman's Principal Health Care Provider for an Ongoing Course of Treatment pursuant to a treatment plan specifying needed services and time frames as determined by your Primary Care Physician or Woman's Principal Health Care Provider, the consulting Physician or Provider and the Plan.

Surgery ……means the performance of any medically recognized, non-Investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Plan.

Totally Disabled ……means, with respect to an Eligible Person, an inability by reason of illness or injury to perform his regular or customary occupational duties or, with respect to a covered person other than the Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

Urgent/Expedited Clinical Appeal ……means an appeal of a clinically urgent nature that relates to health care services, including, but not limited to, procedures or treatments ordered by a health care provider that, if a decision is denied, may significantly increase the risk to your health.

Woman's Principal Health Care Provider (WPHCP) ……means a physician licensed to practice medicine in all of its branches, specializing in obstetrics or gynecology or specializing in family practice.

CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED PUBLIC EMPLOYEES

NOTE: The CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED PUBLIC EMPLOYEES applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

Public employees and surviving spouses of such employees who are eligible for continued group health coverage under Sections 367 (g), (h) and (i) of the Illinois Insurance Code may continue their coverage under this Certificate subject to the following conditions:

1. The public employee or surviving spouse must be covered under this Certificate up to the date of eligibility for continued group health coverage. If such employee or spouse has Family Coverage, he may continue to have Family Coverage.
2. Group coverage can be continued until the public employee or surviving spouse is no longer eligible, as specified in Sections 367 (g), (h) and (i) of the Illinois Insurance Code, subject to all of the termination provisions of this Certificate (for example, termination of the Group's Policy or reaching the limiting age for dependent children). Coverage for a surviving spouse will end if such spouse should remarry. It is the employee/spouse's responsibility to inform the Plan of his loss of eligibility.
3. The total monthly premium for this continuation of coverage must be paid by the Group to the Plan, whether such premium is deducted from a pension payment or paid directly to the Group by the public employee or surviving spouse.
4. If the public employee or surviving spouse who is continuing coverage under this Certificate becomes eligible for Medicare, the benefits under this Certificate will be supplemental to the benefits provided under Medicare.
5. If the public employee or surviving spouse should choose to convert his or her group coverage to a ''direct-payment'' conversion policy, as described above under Conversion Privilege, such employee or spouse will no longer be eligible for this continuation of group coverage.

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GROUP ADMINISTRATORS DENTAL PPO BENEFIT SUMMARY

DENTAL PLAN DOCUMENT

This Plan Document becomes effective as of January 1, 2000.

WHEREAS, the Northwest Suburban Special Education Organization (NSSEO) desires to establish a plan to maintain dental benefits for its employees who are beneficiaries of the Plan, it therefore creates and establishes the Northwest Suburban Special Education Organization (NSSEO) Dental Care Plan, hereinafter referred to as the "Plan" and this document thereinafter referred to as the "Plan Document."

Purpose

The purpose of this Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement for all or a portion of covered dental expenses.

Benefits of this Plan shall be payable for expenses incurred on the effective date of this Plan Document, and after, except as specified.

This Plan Document supersedes all other Prior Plan Documents and issued amendments and shall be the sole document used in determining benefits for which Covered Persons are eligible and may be amended from time to time by the Plan Administrator to reflect changes in benefits or eligibility requirements. It is not in lieu of and does not affect any requirements for coverage by Workers' Compensation. Any change so made shall be binding on each Covered Person and on any other individual or individuals referred to in this Plan Document.

Wherever used in this Plan Document, masculine pronouns shall include both masculine and feminine genders and the singular shall include the plural unless the context indicates otherwise.

The fiscal records for the Plan are kept on a plan year basis ending on each December 31st.

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SECTION 1 -- DEFINITIONS

The term **Employer** means the Northwest Suburban Special Education Organization (NSSEO).

The term **Plan Administrator** means the Northwest Suburban Special Education Organization (NSSEO).

The term **Claims Administrator** means Gallagher Benefit Administrators, Inc.

The terms **Accident** and **Accidental** mean an unforeseen or unexplained sudden occurrence by chance, without intent or volition.

The terms **Active Work** and **Actively at Work** as used in this Plan Document mean active full-time performance of all customary duties of his occupation at any location of business to which the Employer requires the Participant to travel. A Participant shall be deemed "Actively at Work" on each day of a regular paid vacation, and on a regular nonworking day on which he is not disabled, provided he was "Actively at Work" on the last preceding working day.

The term **Appliance** as used in this Plan Document means a device used to replace missing parts, to provide function or for therapeutic purposes. The term includes dental prostheses, splints, orthodontic appliances and obturators.

The term **Calendar Year** means that period of time beginning on the first day of January in any Calendar Year and ending on the last day of December in the same Calendar Year.

The term **Covered Person** means a Participant or his Dependent who has enrolled for coverage under this Plan. Covered Person also means an individual having Plan coverage under the Plan's Continuation of Benefits provisions.

The term **Dental Service** means a professional dental service which is included in the list of dental services under Covered Dental Expenses and is rendered by a dentist in the necessary treatment of Accidental Injury, dental disease or defect. It shall also mean:

1. the scaling and cleaning of teeth by a licensed dental hygienist or dental assistant if performed under the supervision and direction of a dentist and a charge is made for such service by the dentist;

2. laboratory services for preparation of dental restoration and dental prosthetic devices if the dentist includes the cost of such services or devices in the charges for these services.

The term **Dependent** means an individual that meets the eligibility requirements described under Section 2 of this Plan to become a Covered Person eligible to receive Dependent Benefits.

The term **Dependent Benefits** means the coverage provided under this Plan Document with respect to a Covered Person who is a Dependent of a Participant.

The term **Endodontics** means the branch of dentistry concerned with the treatment of teeth having damaged pulp; root canal therapy.

The term **Family Member** means a Participant or his Dependent. Under any benefit section, a "covered family member", as of any given time, is a Family Member for whom coverage is then in force under the section.

The term **Incurred Charge** means the charge for a service or supply is considered to be incurred on the date it is furnished except:

1. 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.

2. 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.

3. Expenses for relining or rebasing of an existing partial or complete denture shall be deemed incurred on the first day of preparation of the reline or rebase of such denture provided the person remains continuously covered during the course of treatment.

4. 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.

5. Expenses or charges for orthodontic services shall be deemed incurred on the date the initial active appliance was installed.

The term **Injury** means trauma or damage to the body by an outside force occurring while the individual is a Covered Person and which results in loss covered by the Plan.

The term **Necessary Service or Supply** means a service or supply broadly accepted by the dental profession as essential to the care or treatment of the teeth and/or surrounding tissues and structures.

The term **Oral Surgery** means the branch of dentistry concerned with surgical procedures in and about the mouth and jaws.

The term **Orthodontics** means the branch of dentistry concerned with the detection, prevention and correction of abnormalities in the positioning of the teeth in their relationship to the jaws. Commonly, straightening teeth.

The term **Palliative** means an alleviating measure. To relieve.

The term **Periodontics** means the science of examination, diagnosis and treatment of diseases affecting the periodontium.

The term **Participant** means an employee who meets the eligibility criteria described under Section 2 of this Plan to become a Covered Person eligible for Personal Benefits.

The term **Periodontium** means collectively the tissues which surround and support the tooth: the gingiva, the cementum, the periodontal membrane, and the alveolar or supporting bone.

The term **Personal Benefits** means coverage provided under this Plan Document with respect to a Covered Person who is enrolled not as a Dependent.

The term **Physician** means a medical doctor or surgeon (M.D.), an osteopath (D.O.), or a dentist or dental surgeon (D.D.S., D.M.D.), who is licensed as required by the law of the state in which he practices or, in the absence of such law, recognized by the state association.

The term **Physician Visit** means a personal interview between the patient and a Physician and does not include telephone calls or interviews in which the Physician does not see the patient for treatment.

The term **Prior Coverage** or **Prior Plan** means any plan or policy of group accident and health benefits provided by the Employer (or its predecessor) which has been replaced by coverage under this Plan Document.

The term **Reasonable and Customary** means the charge made by a Physician or supplier of services, medicines, or supplies which does not exceed the general level of charges made by others rendering or furnishing like services, medicines, or supplies, within an area in which the charge is incurred for Sickness or Injury comparable in severity and nature to the Sickness or Injury being treated. The term area, as it would apply to any particular service, medicine, or supply, means a county or such greater area as is necessary to obtain a representative cross-section of level of charges.

The term **Total Disability** means the Participant is unable, as a result of Sickness or Injury, to perform the normal duties of his occupation and is not performing work of any kind for wage or profit.

The term as it applies to a Dependent means the Dependent is unable, as a result of Sickness or Injury, to perform the normal duties appropriate to a person in good health of the same sex and age; and it means a Dependent child is confined in a hospital or extended care facility.

The term **Trust** means any trust established by the Employer as a funding vehicle for the benefits provided by this Plan.

The term **Trustee** means the person, firm, corporation, or other entity appointed by the Employer to manage the Trust.

SECTION 2 -- ELIGIBILITY

PARTICIPANT

An active full-time employee, who is directly employed in the regular business of and compensated for services by the Employer and regularly works 31 or more hours a week; or

A retired or disabled employee who is fully qualified for immediate receipt of IMRF retirement or disability benefits under Article 7 of the Illinois Pension Code on the date of retirement or disability, and who was covered under this Plan on the date immediately prior to that date.

Part-time or temporary employees cannot be considered Participants.

An employee who elects any other dental plan option which may be offered by the Employer cannot be considered a Participant and cannot be covered for benefits under this Plan.

ELIGIBILITY DATE

A Participant hired on or after the effective date of this Plan becomes eligible for Personal Benefits after completing a waiting period of one month continuous employment.

DEPENDENT

Participant's spouse (unless legally separated); and

Participant's unmarried child from birth to the date he attains age 19.

Participant's unmarried child at least 19 years of age to the date he attains 23 years of age provided the child is a full-time student in an accredited school and is principally dependent (named as an exemption on the Participant's most current Federal Income Tax Return) on the Participant for his support and maintenance.*

Participant's unmarried child already covered under the plan, who, from the date his coverage would otherwise terminate under the Plan, is both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) principally dependent (named as an exemption on the Participant's most current Federal Income Tax Return) upon the Participant for support and maintenance* (see Section 5).

A "child" is the Participant's:

- natural born child or legally adopted child. An adopted child shall be considered a "child" from the moment the child is placed in the custody of the parents for adoption; or

- a stepchild or any child who resides in the Participant's household in a regular parent-child relationship and is principally dependent (named as an exemption on the Participant's most current Federal Income Tax Return) on the Participant for support and maintenance*.

*(Proof may be required.)

If both parents of a child are covered for Personal Benefits, either but not both may cover the child as a Dependent.

Any individual who is eligible as a Participant is not a Dependent.

ELIGIBILITY. Each Participant becomes eligible to cover his Dependents for Dependent Benefits on the later of the following dates:

1. the date he is eligible for Personal Benefits, if he then has a Dependent (spouse and/or child); and

2. the date he acquires an eligible Dependent through marriage, birth, adoption, or otherwise as stated above.

If a Participant's Dependent is employed and covered under the NSSEO group plan the day immediately following the date such coverage terminates due to the termination of the Dependent's employment may also be deemed to be the date the Participant first acquires that Dependent and any other Dependent covered under such group plan or plans.

SECTION 3 -- EFFECTIVE DATES

PARTICIPANT

Personal Benefits are noncontributory.

The coverage under this Plan Document for Personal Benefits is noncontributory (Participant does not contribute toward the cost) and becomes effective on the date eligible, provided the Participant has enrolled.

If the Participant does not want to be covered for Personal Benefits, he must sign a waiver of benefits form.

Dual Option Transfer

If a Participant is a member of any other dental option sponsored by the Employer, and he chooses to transfer coverage from the other dental option to this dental plan, he must wait until the annual open enrollment period held during the month of September. Coverage will be effective on the subsequent October 1st. The Late Enrollment provision will not apply.

Late Enrollment

If the Participant does not enroll within 31 days after the date he becomes eligible, that Participant will not be covered until a signed enrollment form is received by the Employer. Coverage will be effective on the date specified by the Employer or Plan Administrator. No benefits will be payable for Major Services or Orthodontia for six months following such late enrollment.

Special Enrollment

If a Participant declines coverage under this Plan when first eligible to enroll because he had other health coverage, including COBRA Continuation Coverage, and he loses the other health coverage, he may enroll for coverage within 31 days of the occurrence. Coverage will be effective on the date of the occurrence.

If a Participant acquires a Dependent through marriage, he may enroll for coverage within 31 days of the marriage. Coverage will be effective on the date of the marriage.

If a Participant acquires a Dependent through birth, adoption or placement for adoption, he may enroll for coverage within 31 days of the birth, adoption or placement for adoption. Coverage will be effective on the date of the acquisition.

DEPENDENT

Dependent Benefits are contributory.

When a Participant enrolls his Dependents and authorizes any required contributions for Dependent Benefits, Dependent Benefits will become effective as follows:

- If a Participant has eligible Dependents on the effective date of his coverage and he has enrolled and authorized contributions for Dependent Benefits on or prior to the Participant's effective date, then coverage for those Dependents will be effective on the date the Participant's coverage begins.

- If a Participant does not have eligible Dependents on the effective date of his coverage and later acquires an eligible Dependent(s) as defined in Section 2 of this Plan Document, and if he enrolls and authorizes any required contributions for Dependent Benefits on or prior to the date of acquisition, then coverage for the Dependent(s) will be effective on the date of acquisition

- If a Participant enrolls for Dependent Benefits within 31 days after the date eligible, then Dependent coverage will be effective on the date the enrollment form is signed. However, coverage will be retroactive to the date of birth if the Participant's eligible Dependent is a newborn.

If the Participant is already enrolled for Dependent Benefits, then Dependent Benefits for a newly acquired Dependent will become effective on the date of acquisition.

Dependent Benefits will not become effective for the Dependents of a Participant unless he is covered, or simultaneously becomes covered, for Personal Benefits.

No individual may be covered simultaneously both as a Participant and as a Dependent.

Late Enrollment

If the Participant does not enroll his Dependents within 31 days after the date they become eligible, those Dependents will not be covered until a signed enrollment form is received by the Employer. Coverage will be effective on the date specified by the Employer or Plan Administrator. No benefits will be payable for Major Services or Orthodontia for six months following such late enrollment.

Special Enrollment

If a Participant declined coverage for his Dependents under this Plan when first eligible to enroll because his Dependents had other health coverage, including COBRA Continuation Coverage, and they lose the other health coverage, he may enroll for Dependent Benefits within 31 days of the occurrence. Coverage will be effective on the date of the occurrence.

If a Participant acquires a Dependent through marriage, he may enroll for Dependent Benefits within 31 days of the marriage. Coverage will be effective on the date of the marriage.

If a Participant acquires a Dependent through birth, adoption or placement for adoption, he may enroll for Dependent Benefits within 31 days of the birth, adoption or placement for adoption. Coverage will be effective on the date of the acquisition.

SECTION 4 -- TERMINATION OF COVERAGE

PARTICIPANT. The coverage of any Participant covered under this Plan Document will cease on the earliest of the following dates except as provided in Section 5 -- Continuation of Benefits (if applicable):

1. The date this Plan Document terminates.
2. The date ending the period for which any required contributions **(if required)** have been paid.
3. The date he is no longer eligible for coverage under this Plan Document.
4. The date he begins active duty in the Armed Forces of any country for longer than two weeks.
5. The date of death.
6. Thirty days following the date his employment terminates, or August 31st of the school year should he fail to report for duty at the start of the current school year.
7. Retirement, except as indicated below.
8. The date he elects in writing that termination of coverage occurs.

Cessation of active work will result in termination of coverage, except that:

If a Participant is absent from work because of sickness or Injury, his coverage may be considered to continue until terminated by the Employer, provided the Participant makes any required contributions;

If a Participant is absent from work because of temporary layoff or suspension of the Employer's business operations, his coverage may be considered to continue until terminated by the Employer, but for no longer than the end of the second month after the calendar month in which the layoff started, provided the Participant makes any required contributions;

If a Participant is absent from work because of approved leave of absence, his coverage may be considered to continue until terminated by the Employer, but for no longer than 12 months from the date the leave started, provided the Participant makes any required contributions;

With respect to a retired/disabled employee receiving IMRF benefits pursuant to the Illinois Pension Code, coverage may be considered to continue until the Participant is no longer eligible for such pension benefits, provided the Participant makes any required contributions.

An Employer must signify an employee's termination of employment or other event terminating coverage by notifying Gallagher Benefit Administrators, Inc. in writing.

If subsequent to termination of service, a Participant is reemployed or reinstated as an eligible Participant, he will be treated in the same manner as a new Participant at the date of such reemployment or reinstatement.

DEPENDENT. Coverage with respect to **each** Dependent covered under this Plan Document shall cease on the earliest of the following dates:

1. The date such individual ceases to be a Dependent as defined in this Plan Document.
2. The date the Dependent begins active duty in the Armed Forces of any country for longer than two weeks.
3. The date the Dependent becomes eligible under the Plan as a Participant.

Coverage with respect to *all* Dependents of a Participant covered under this Plan Document shall cease on the date the Participant's benefits terminate, except as provided in Section 5, Continuation of Benefits. A Participant's Dependents' benefits shall also terminate on the date the Participant requests such coverage be terminated, but in no event prior to the date of such request.

* * *

When coverage of a Participant and/or Dependent terminates, benefits shall not be provided for any services after termination even though such services are furnished as a result of a sickness or Injury occurring before such termination of coverage unless otherwise provided under the Extended Benefit Provisions.

SECTION 5 -- CONTINUATION OF BENEFITS

(As Required By Federal Law)

Federal Legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that a Participant and/or Dependent may elect to continue coverage up to the length of time specified below after the occurrence of any of the following events which would normally result in termination of coverage under the Plan, provided any required contributions are paid.

Coverage may be continued up to 18 months for a Participant and/or Dependent in the event of the termination of employment (other than by reason of gross misconduct) or the reduction of hours of a Participant.

Continuation coverage may extend from 18 months to 29 months for a Participant and/or Dependent who is or becomes totally disabled (as determined by the Social Security Administration) at any time during the first 60 days of COBRA continuation coverage, provided that such Participant and/or Dependent has given notice of the disability within 60 days of the Social Security determination and requested the extended continuation period before the end of the first 18 months.

Coverage may be continued up to 36 months for a Dependent in the event of:

1. The death of the Participant;

2. The divorce or legal separation of the Participant from his/her spouse;

3. The Participant becomes entitled to Medicare, and as a result he and his Dependents are no longer considered eligible for coverage under the Plan;

4. A Dependent child ceases to be a Dependent under the terms of this Plan.

Coverage will be continued only for those Participants and/or Dependents who were covered under the Plan on the day immediately preceding termination. However, if a child is born or placed for adoption with the Participant during the period of COBRA continuation coverage, such child is entitled to receive COBRA continuation coverage with independent COBRA rights.

Coverage will not be continued beyond the earliest of the following dates:

1. The date ending the period for which any required contribution has been paid (within the grace period);

2. The date the Participant and/or Dependent first becomes entitled to Medicare, or first becomes covered under another group health plan and is not subject to that plans preexisting limitations;

3. The date the Employer ceases to provide any group health plan.

This section shall not apply to such Participants or Dependents for whom a greater period of continuation is provided elsewhere in this Plan Document.

Conformity with the Law

If any provision of this Section is contrary to the Consolidated Omnibus Reconciliation Act of 1985 (as amended), the provision is changed to comply with the law.

Family Security Benefits -- Any Dependent Benefits which are in effect under this Plan at the time of the Participant's death will be continued after such death while any required contributions for such coverage are continued.

However, Dependent Benefits will not be continued beyond the earliest of the following occurrences:

The end of a 90 day period after the Participant's death.

Termination of Dependent Benefits under the Plan.

The end of the period for which contributions (if required) have been paid.

As to the Participant's spouse only, when the spouse remarries or becomes eligible for other coverage.

As to the Participant's Dependent child only, when the child ceases to meet the definition of a Dependent or becomes eligible for other group health coverage.

However, in addition to the above, and only with respect to the surviving spouse of a retired/disabled employee who was receiving IMRF benefits pursuant to the Illinois Pension Code, coverage will be continued during that spouse's lifetime provided the spouse is receiving pension benefits pursuant to the Illinois Pension Code.

Dependent Benefits may be provided under this Plan to a Participant's Dependent child, born after the Participant's death, as long as coverage for his other Dependents is being continued under this section.

For the purposes of filing proof of loss and payment of claims, the Participant's spouse, if living, will be considered as the Participant, otherwise the Dependent child (or his legal guardian) claiming benefits will be so considered.

This Section will not apply to a Dependent for whom a greater period of continuation of coverage is provided elsewhere in this Plan Document.

Coverage For Mentally Retarded and/or Physically Handicapped Dependent Children -- Any Dependent Benefits under this Plan for an unmarried Dependent child, already covered under the Plan, may be continued beyond the date the child attains the limiting age for Dependent children, if all the following tests are met:

- On the date the child attains the limiting age, he is incapable of self-sustaining employment because of mental retardation or physical handicap which is objectively verifiable by medical tests.
- The child, on that date, is chiefly dependent on the Participant for support.
- Due proof of the mental retardation or physical handicap is furnished to the Employer not later than 31 days after the date the child attains the limiting age.

However, Dependent Benefits for the child may not be continued beyond the earliest of the following:

- cessation of the physical handicap;
- failure to furnish any required proof of mental retardation and/or physical handicap or to submit to any required examination;
- termination of Dependent Benefits for the child for any reason other than attaining the limiting age.

The Employer will have the right to require due proof of the continuation of the mental retardation and/or physical handicap and will have the right and opportunity to examine the child whenever the Employer may reasonably require it during such continuation. After two years have elapsed from the date the child attained the limiting age, only one examination will be required per year.

SECTION 6 -- COORDINATION OF BENEFITS PROVISIONS

The provisions of this Section (herein called these provisions) are for coordination of all benefits under this Plan Document with other benefits.

DEFINITION OF WORDS AND TERMS USED IN THIS SECTION: The word "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by:

1. any group, franchise, hospital or medical service, prepayment or other coverage arranged through any employer, trustee, union, employee benefit or other employee association;

2. any coverage under governmental programs, and any coverage required or provided by any statute;

3. any coverage sponsored by, or provided through, a school or other educational institution.

The word **Plan** shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

The term **this Plan** means those Sections of this Plan Document which provide the benefits that are subject to these provisions.

The term **Allowable Expense** means any necessary, Reasonable and Customary item of expense, or such other item of expense at least a portion of which is covered under at least one of the Plans covering the individual for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

The term **Claim Determination Period** means, for any individual, that portion of a Calendar Year during which he would be eligible to receive benefits under this Plan Document in the absence of this Section.

EFFECT ON BENEFITS: These provisions shall apply in determining the benefits as to an individual covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such individual during such period, the sum of:

1. the benefits that would be payable under this Plan in the absence of these provisions, and

2. the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to these provisions

would exceed such Allowable Expenses.

As to any Claim Determination Period with respect to which these provisions are applicable, the benefits that would be payable under this Plan in the absence of these provisions for the Allowable Expenses incurred as to such individual during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in the next paragraph, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been fully made therefor.

1. If another Plan which is involved in the preceding paragraph and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and

2. if the rules set forth in the next paragraph would require this Plan to determine its benefits before such other Plan;

then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

For the purpose of these provisions, the rules establishing the order of benefit determination are:

1. the benefits of a plan which does not contain Coordination of Benefits provision always shall be determined before the benefits of the plan which does contain a Coordination of Benefits provision;

2. the benefits of a plan which covers the individual on whose expense claim is based other than as a dependent shall be determined before the benefits of a plan which covers such individual as a dependent;

   however, the benefits of a plan which covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a plan which covers that person as a laid off or retired employee or as that employee's dependent;

3. the benefits of a plan which covers a person as an employee who is neither laid off nor retired or a Dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

4. the benefits of a plan covering the child as a Dependent of the father shall be determined before the benefits of a plan covering the child as a Dependent of the mother;

5. if the parents are divorced or legally separated, it is necessary to determine if there is a court decree which establishes financial responsibility for medical, dental or other health care expenses for the child. If there is such a decree, the benefits of the plan covering the parent who has that responsibility shall be determined before the benefits of the plan covering the other parent;

6. if there is no such decree, the benefits of the plan covering the parent who has custody of the child shall be determined before the benefits of the plan covering the other parent;

7. if there is no such decree and the parent with custody of the child has remarried, the order of priority is:

   - the plan covering the parent who has custody;
   - the plan covering the spouse of the parent who has custody, (that is, the stepparent of the child) and;
   - the plan covering the parent without custody.

8. when rules (1) through (7) in this paragraph do not establish an order of benefit determination, the benefits of a plan which has covered the individual on whose expense claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such individual for the shorter period of time.

When these provisions operate to reduce the total amount of benefits otherwise payable as to an individual covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of these provisions shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: For the purpose of determining the applicability of and implementing the terms of these provisions under this Plan or any provision of similar purpose of any other Plan, the Employer may, without the consent of or notice to any individual, release to or obtain from any insurance company or other organization or individual any information, with respect to any individual, which the Employer deems to be necessary for such purposes. Any individual claiming benefits under this Plan shall furnish to the Employer such information as may be necessary to implement these provisions.

FACILITY OF PAYMENT: Whenever payments which should have been made under this Plan in accordance with these provisions have been made under any other Plans, the Employer shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of these provisions, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the Employer shall be fully discharged from liability under this Plan.

RIGHT OF RECOVERY: Whenever payments have been made by the Employer with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of these provisions, the Employer shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Employer shall determine: any individual to or for or with respect to whom such payments were made, any insurance companies, any other organizations.

SECTION 7 -- SUBROGATION/RIGHT OF REIMBURSEMENT

If a Covered Person files a claim under this Plan for dental expenses incurred as a result of an Injury or sickness due to the act of a third party, the Plan Administrator shall have the right to enforce either the Subrogation or Right of Reimbursement provision below.

The Covered Person* must execute any subrogation/right of reimbursement agreement required by the Plan Administrator prior to receipt of any benefits payable under this Plan. Neither the Subrogation nor Right of Reimbursement provisions and/or agreement may be modified by the Covered Person* unless specifically authorized in writing by the Plan Administrator.

The Covered Person* must furnish the Plan Administrator any and all information that the Plan Administrator may reasonably require to protect the Plan's right of subrogation and/or reimbursement, and shall do nothing to prejudice that right.

Subrogation

- The Covered Person* shall fully cooperate with the Plan Administrator in the pursuit of any and all valid claims the Participant or Dependent may have against the third party and/or his insurer arising out of such act;
- The Plan Administrator will be subrogated to any legal claim the Participant or Dependent may have, and is entitled to assert a lien against the third party;
- Notice of a lien is sufficient to establish the Plan's lien against the third party;
- Any recovery by the Plan Administrator will be limited to the amount of any payments made under the Plan for dental expenses resulting from the negligent or intentional act and the cost of prosecuting the claim including attorney's fees and collection fees.

For purposes of this provision, subrogation means the Plan Administrator has the right to act in place of the Covered Person to make a lawful claim or demand against the third party.

CONFLICTING STATUTES: Although the Plan Administrator may choose to enforce either the Subrogation or Right of Reimbursement provision, if the Subrogation provision conflicts with the laws of the State or the governing jurisdiction, then the Subrogation provision shall not be enforced, and the Right of Reimbursement provision will apply.

Right of Reimbursement

- The Covered Person* shall reimburse this Plan from any money received from the Participant's insurer, a third party, or the third party's insurer;
- Reimbursement will be up to the amount of benefits paid by this Plan;
- A pro rata portion of reasonable attorney's fees and court costs incurred by the Covered Person* in obtaining the third party payment may be deducted from the reimbursement.
- The Plan shall not be responsible for any fees or expenses incurred in connection with the recovery unless it shall have agreed in writing to pay those expenses or fees.

The reimbursement agreement will be binding upon the Covered Person* whether the payment received from the third party or its insurer results from:

- a legal judgment, or
- an arbitration award, or
- a compromise settlement, or
- any other arrangement.

It is not necessary that the dental expenses be itemized in the third party payment or that the third party and/or its insurer admit liability.

Also, the Employer is under no obligation to recover such reimbursement on behalf of the Covered Person*.

*or legal representative/guardian of a minor or incompetent

SECTION 8 -- MEDICARE

The term "Medicare" means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Ineligible individuals age 65 and over may purchase Medicare Part A by making application and paying the full cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.

Federal legislation requires that ACTIVE Participants, age 65 and over, be given the option to elect the Employer's Plan primary or Medicare. If the affected Participant elects the benefits of this Plan as primary, the regular benefits of the Plan will apply. If a Participant elects Medicare, no benefits will be available under this Plan.

Federal legislation also requires that the spouse, age 65 and over of any active Participant be given the option to elect the Employer's Plan primary or Medicare. If the affected spouse elects the benefits of this Plan as primary, the regular benefits of the Plan will apply. If the spouse elects Medicare, no benefits will be available under this Plan.

The Plan is the primary payor and Medicare is the secondary payor for services that would have been covered by Medicare in the case of:

a Participant or Dependent spouse of a Participant covered under this Plan because of current employment who is entitled to Medicare benefits because of age;

a Participant or Dependent, covered under this Plan as a result of current employment, who is entitled to Medicare benefits because of total disability;

a Participant or Dependent who is entitled to Medicare because of end stage renal disease until the end of the Medicare secondary coordination period.

When Medicare is the primary payor, and a Participant or Dependent entitled to Medicare incurs:

1. hospital, surgical or other charges covered under Medicare, and
2. charges not covered under Medicare,

this Plan's benefits will cover charges incurred to the extent that they are not covered under Medicare. The C.O.B. provision (Section 6) will apply.

Any of the above individuals must apply for Medicare at the earliest opportunity possible. Individuals not meeting the Medicare entitlement requirements must purchase Part A paying full cost. Additionally, all of the above individuals must purchase Medicare Part B paying the full cost. All such individuals will be considered to be covered under both Medicare Parts A & B whether or not actually covered thereunder.

SECTION 9 -- GENERAL PROVISIONS

ADMINISTRATION. Unless otherwise specified in Section 1, the Employer shall be the Plan Administrator of this Plan. The Plan Administrator shall be in charge of and responsible for the operation and administration of the Plan.

The Plan Administrator is hereby designated the named fiduciary with respect to the administration of the Plan and the Trustee, if any, is designated as the named fiduciary with respect to the investment and management of the assets of the Plan. The Plan Administrator shall have the right from time to time to delegate to such persons or entities such Plan administration duties and responsibilities as the Plan Administrator deems appropriate. The Plan Administrator shall maintain such records as shall be necessary for the administration of the Plan. The Plan Administrator shall file all reports and documents which are required by law to be filed by the Plan Administrator. The Plan Administrator shall adopt and implement such procedures, including, but not limited to, utilization review and case management procedures, as are deemed necessary in the sole discretion of the Plan Administrator to administer the Plan.

The Plan Administrator may appoint a Claims Administrator to receive and initially review and process claims for Plan benefits. Any appeals of denied claims for Plan benefits shall be directed to the Plan Administrator for determination. The Plan Administrator shall have the discretionary authority to determine eligibility for Plan benefits and to construe the terms of the Plan, including the making of factual determinations.

The Plan Administrator shall be responsible for forwarding Participants' applications to the Claims Administrator. The Plan Administrator shall also be responsible for notifying the Claims Administrator in writing of any changes with respect to any Covered Persons entitled to coverage, or any other facts necessary for determining Plan coverages and for processing claims for Plan benefits.

This Plan is funded by contributions from the Employer and any required contributions from Covered Persons. The Employer reserves the right to change the contribution rates for Covered Persons at any time and from time to time.

ASSIGNMENT. Benefits provided for by this Plan Document shall not be assignable, however, subject to written direction of the Covered Person*, all or a portion of the benefits, if any, provided for by this Plan for covered dental services may be paid directly to the provider of such service, but it is not required that the service be rendered by a particular provider.

PROOF OF CLAIMS. The payment of any benefit set forth in this Plan Document is subject to the provision that the Covered Person furnish such proof and releases as the Employer or Plan Administrator may reasonably require before approving the payment of any such benefit.

Proof of claim must be given to the Employer or Claims Administrator not later than 15 months after the covered expense is incurred by the Covered Person. Proof of claim consists of completing and filing a claim form with the Claims Administrator. Failure to provide proof of claim within the time specified will not invalidate or reduce any claim if it was not reasonably possible to furnish such proof within the time specified.

PHYSICAL EXAMS. The Plan Administrator, or its Designee shall have the right and opportunity to have a Physician designated by it examine the Covered Person whose Injury or sickness is the basis of claim when and so often as it may reasonably require during the pendency of claim hereunder.

CLAIMS REVIEW PROCEDURES. If an applicant's initial claim for Plan benefits is denied in whole or in part, such applicant may request a review of the denied claim by the Claims Administrator. The request for review of the denied claim must be in writing and received by the Claims Administrator within 60 days after the claim was denied. The request for review shall contain the reasons for the request and any additional information or documentation to support the claim for benefits. The Claims Administrator shall consider the request for review and notify the applicant of its decision within 60 days of its receipt of the request. The Claims Administrator's decision shall be in writing and shall set forth:

- the specific reason or reasons for the denial;
- specific reference to pertinent Plan provisions on which denial is based;
- a description of any additional material or information necessary for the claimant to perfect the claim; and
- an explanation of the Plan's claim appeal procedure.

If the decision of the Claims Administrator is to deny the applicant's claim, the applicant may appeal that denial to the Plan Administrator. The appeal must be in writing and received by the Plan Administrator within 60 days after the applicant received the decision of the Claims Administrator. In the event of an appeal, the applicant or the applicant's authorized representative may review pertinent Plan documents relating to the claim denial and may submit issues and comments in writing.

A decision on the appeal will be made within 60 days after receipt of the appeal. The decision will be in writing and will include specific reasons for the decision and specific references to the pertinent Plan provisions on which the decision is based.

FACILITY OF PAYMENT. If any Covered Person is, in the opinion of the Plan Administrator, legally incapable of giving a valid receipt for any payment due him and no guardian has been appointed, the Plan Administrator may, at its option, make such payment to the individual or individuals as have, in the Plan Administrator's opinion, assumed the care and principal support of such Covered Person. If the Covered Person should die before all amounts due and payable to him have been paid, the Plan Administrator may, at its option, make such payment to the executor or administrator of his estate or to his surviving wife, husband, mother, father, child or children, or to any other individual or individuals who are equitably entitled thereto.

Any payment made by the Plan Administrator in accordance with these provisions shall fully discharge the Plan to the extent of such payment.

CHANGE OR DISCONTINUANCE OF BENEFITS. The Employer may at any time change or discontinue the benefits provided in this Plan Document, but no change or discontinuance may affect in any way the amount or the terms of any benefits payable under this Plan Document prior to the date of such change or discontinuance. Any change or discontinuance of the benefits provided in this Plan Document shall be evidenced by a written instrument signed by the Employer.

NONDISCRIMINATION. In the administration of this Plan, the Plan Administrator will act so as not to discriminate unfairly between individuals in similar situations at the time of the action. The Claims Administrator will be entitled to rely on any such action, without being obliged to inquire into the circumstances.

STATEMENTS. No person has the authority to make any verbal statements of any kind at any time which are legally binding upon the Employer, Plan Administrator or alter this Plan Document. No written statement made by a Covered Person shall be used by the Claims Administrator in a contest unless a copy of the instrument containing the statement is or has been furnished to the Covered Person, or the person making the claim.

No statement made by the Employer or Plan Administrator or Covered Person shall void any coverage or reduce any benefits or be used in defense of a claim unless it is in writing.

DISCONTINUANCE OF PLAN. The Plan Administrator may discontinue this Plan with respect to any or all coverage of all Covered Persons, by giving to the Claims Administrator written notice stating when, after the date of such notice, such discontinuance shall become effective; but no such discontinuance shall become effective with respect to any coverage of the Covered Persons of an Employer during any period for which a contribution has been paid to the Claims Administrator with respect to such coverage.

The Claims Administrator reserves the right to discontinue its servicing of this Plan, at any time after the end of the grace period allowed for payment of a service fee which has not been paid, by giving the Employer or Plan Administrator written notice of the discontinuance date. This right is subject to the terms of any applicable law or regulation.

The Claims Administrator may also discontinue its servicing of this Plan in its entirety, at any time, by giving the Plan Administrator advance written notice of the discontinuance date, but the date shall not be earlier than 31 days after the date of the notice unless mutually satisfactory to the Plan Administrator and the Claims Administrator.

If this Plan discontinues as to any coverage of the Covered Persons of an Employer, the Employer or Plan Administrator will be jointly and severally liable to the Claims Administrator for all unpaid service fees for the period in which the Claims Administrator performed services for this Plan.

EFFECT OF PRIOR COVERAGE. Coverage for any Covered Person under this Plan Document replaces any prior coverage in effect for that Covered Person provided by the Employer under any immediately Prior Plan document or policy.

Benefits paid to Covered Persons under such immediately Prior Plan document or policy which were charged against such Prior Plan's maximum lifetime limits (if any) and which accumulate or apply in more than one calendar, plan or fiscal year, shall be carried over and charged against any such maximum lifetime limits under this Plan.

DEDUCTIBLE REQUIREMENT. If the Prior Plan coverage deductible requirement had been fully satisfied during the Calendar Year in which this Plan took effect, this Plan's deductible requirement will be considered satisfied for the balance of that year. Charges which were incurred under the Prior Plan coverage, and which did not qualify for benefits under the Prior Plan coverage solely because of its deductible requirements, will count toward satisfying this Plan's deductible requirement if they meet the following conditions:

1. the charges would qualify as covered dental expenses under this Plan, and

2. this Plan's deductible requirement is satisfied within the prescribed period.

DATA REQUIRED. The Employer or Plan Administrator must furnish the Claims Administrator all information the Claims Administrator reasonably requires as to matters pertaining to this Plan. All material which may have a bearing on coverage or contributions will be open for inspection by the Claims Administrator at all reasonable times during the continuance of this Plan and until the final determination of all rights and obligations under this Plan.

CLERICAL ERROR. Any clerical error (by the Employer, Plan Administrator, or the Claims Administrator) in keeping pertinent records, or a delay in making any entry, will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

MISSTATEMENTS. If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, an equitable adjustment of contributions will be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under this Plan and its amount.

CONFORMITY WITH THE LAW. If any provision of the Plan Document or Employer's Plan is contrary to any law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

APPLICABLE LAW. The Plan shall be construed and administered in accordance with the laws of the State of the Employer's principal place of business.

SEVERABILITY. In the event that any provision of the Plan shall be held to be illegal or invalid for any reason by a court of competent jurisdiction, such illegality or invalidity shall not affect the remaining provisions of the Plan and the Plan shall be construed and enforced as if such illegal or invalid provision had never been contained in the Plan.

LIABILITY OF DIRECTORS, OFFICERS, AND EMPLOYEES. To the extent permitted by law, no director, officer, or employee of the Employer shall incur any personal liability of any nature for any act done or omitted to be done in good faith in connection with his duties relative to the Plan, except in cases of dishonesty, gross negligence or willful misconduct. Such directors, officers, and employees shall be indemnified and held harmless by the Employer from and against any liability, including reasonable attorneys' fees, to which any of them may be subjected by reason of any such good faith act or conduct in their director, officer, or employee capacity. Any indemnification payments made by reason of this provision shall not be made from the assets of the Plan nor any Trust established in conjunction with the Plan.

PROTECTION AGAINST CREDITORS. To the extent permitted by law and except as otherwise provided in this Section, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, assignment, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void.

NO EMPLOYMENT CONTRACT. Nothing in the Plan shall confer any rights of continued employment to any employee of the Employer or in any way alter an employee's status as a terminable, at will employee of the Employer. Furthermore, the Plan does not constitute a contract of employment.

NO VESTING. The benefits provided under this Plan to Covered Persons are neither guaranteed nor vested benefits.

RECOVERY OF BENEFIT OVERPAYMENT If any Plan benefit paid to or on behalf of a Covered Person should not have been paid or should have been paid in a lesser amount, and the Covered Person* failed to repay the amount promptly, the overpayment may be recovered by the Employer from any monies then payable, or which may become payable, in the form of salary or benefits payable under any of the Employer's sponsored benefit plans or programs including this Plan. The Employer also reserves the right to recover any such overpayments by appropriate legal action.

HEADINGS. The headings of the Plan are for reference only and shall not determine the interpretation or construction of this Plan.

MULTIPLE COUNTERPARTS. This Plan Document may be executed in multiple counterparts, each of the same force and effect.

* or legal representative of a minor or incompetent

SECTION 10 -- HEALTH MAINTENANCE ORGANIZATION

Transfers from HEALTH MAINTENANCE ORGANIZATIONS. Eligibility for Former Health Maintenance Organization (H.M.O.) Members.

If the Employer contracts with a Health Maintenance Organization and the Employer provides a H.M.O. option as an alternative to this Plan, each employee, who is a member of that H.M.O., will have the opportunity to transfer coverage from that H.M.O. to this Plan during the open enrollment period. Coverage under this Plan will become effective on the date agreed upon by the Employer.

The Employer will provide the details of any HMO option.

SECTION 11 -- SCHEDULE OF BENEFITS

DENTAL BENEFITS	MAXIMUM
BENEFIT - **Dental**	$3,000 per Calendar Year
BENEFIT - **Orthodontia**	$1,500 lifetime
DEDUCTIBLE (waived for Preventive Services)	$50 per Calendar Year, per individual (maximum of $150 per family per Calendar Year)
COPAYMENT PERCENTAGE FOR:	
• Preventive Services	100%
• Basic Service	80%
• Major Services	80%
• Orthodontia	50%

SECTION 12 -- DENTAL BENEFITS

BENEFITS PAYABLE. If a Covered Person receives any necessary Dental services or treatment specified in this Section, the Plan, subject to all the provisions of this Plan Document will pay:

100% of Reasonable and Customary expenses for covered preventive services.

After the deductible, 80% of Reasonable and Customary expenses for covered basic and major services and 50% of Reasonable and Customary expenses for covered orthodontia services.

MAXIMUM BENEFIT. For each Covered Person, the maximum amount payable is the Maximum Benefit stated in the Schedule of Benefits.

DENTAL DEDUCTIBLE AMOUNT. The dental deductible amount for each Calendar Year with respect to each Covered Person is the deductible amount in the Schedule of Benefits.

The dental deductible does not apply to Preventive services.

If in any Calendar Year covered Family Members shall cumulatively incurred sufficient Covered Expenses to satisfy the deductible specified, the deductible shall be deemed to be satisfied for all covered Family Members in that Calendar Year.

Any part of the deductible satisfied by charges incurred on or after October 1 will go toward the satisfaction of the deductible in the subsequent Calendar Year.

EXTENDED BENEFITS. Dentures or bridges - If a final impression for a denture has been taken, or tooth for a bridge has been prepared, before coverage ceased, then charges for the construction and/or insertion of such denture or bridge will be considered as eligible expenses only to the extent that such construction or insertion procedures are performed within 3 calendar months after termination of coverage.

Dental procedures, other than dentures or bridges, will be considered as eligible expenses if such procedures relate to a particular multiple-appointment dental procedure which had commenced before coverage ceased, but only to the extent that such procedures are performed within 3 calendar months after termination of coverage.

ALTERNATE PROCEDURES. If two (2) or more alternate procedures, services, or courses of treatment may satisfactorily correct a dental condition, the least expensive procedure will be considered for payment. Such determination will be made by the Claims Administrator based upon professionally endorsed standards of dental care.

PREDETERMINATION OF DENTAL CARE COSTS. If the expenses to be incurred for the performance of a Dental Service or series of Dental Services can reasonably be expected to be $200 or more, those expenses may be included as Covered Dental Expenses, provided the Claim Administrator agrees, through Pretreatment Review prior to the performance of the service or services, to accept those expenses as Covered Dental Expenses. If the Claims Administrator does not so agree through Pretreatment Review, or if a description of the procedures to be performed and an estimate of the Dentist's charges are not submitted in advance, the amount of expenses included as Covered Dental Expenses will be determined by the Claim Administrator taking into account alternate procedures, services, or courses of treatment based upon professionally endorsed standards of dental care.

The Participant is responsible for the total dentist's bill irrespective of the amount payable by the Plan.

COVERED DENTAL EXPENSES include Reasonable and Customary necessary expenses incurred for the services and supplies listed below:

Covered Preventive Services

Periodic oral examinations, but not more than twice during any twelve (12) consecutive months.

Prophylaxis, including cleaning, routine scaling and polishing, but not more than four (4) times per Calendar Year.

Topical fluoride application for Dependents age 19, not more than once during any twelve (12) consecutive months.

Palliative emergency treatment and emergency oral examinations.

Topical application of sealant on a posterior tooth for a person less than 14 years old, not more than one treatment per tooth in any thirty-six (36) consecutive months.

Space maintainers, fixed unilateral, excluding orthodontics.

Dental X-rays as follows:

- full mouth X-rays but not more than once during any thirty-six (36) consecutive months;
- bitewing X-rays, but not more than two (2) set(s) in any twelve (12) consecutive months;
- other dental X-rays as deemed necessary.

Infection control supplies.

Covered Basic Services

Fillings (amalgam, composite, plastic and acrylic).

Extractions.

Endodontics (root canal therapy). Any X-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate covered expense.

Repair of removable dentures.

Denture adjustments and relining and/or rebasing.

Recementing of crowns, inlays and/or bridges.

Biopsies of oral tissue.

Pulp vitality tests, but not more than once during any twelve (12) consecutive months.

Home visits by a Physician when Medically Necessary in order to render a covered Dental Service.

Oral surgery.

Apicoectomy.

Hemisection.

General anesthesia administered in connection with a covered dental service only if administered by an individual licensed to administer general anesthesia.

Injection of antibiotic drugs.

Periodontics:

Occlusal equilibration, when no restoration is involved.

Gingivectomy and gingivoplasty.

Gingival curettage.

Scaling and root planing.

Osseous surgery (osteoplasty and ostectomy), including flap entry and closure.

Surgical periodontic examination.

Mucogingivoplastic surgery.

Management of acute periodontal infection and oral lesions.

Covered Major Services

Inlays (not part of bridge).

Onlays (not part of bridge).

Crowns (not part of bridge).

Inlays, onlays, gold fillings, crowns, either restorative or as part of a bridge, including precision attachments for dentures.

Fixed bridge repairs.

Initial dentures, full and partial, and bridges, fixed and removable as follows:

1. Dentures to replace one or more natural teeth extracted while covered under these benefits.

2. Bridgework to replace one or more natural teeth extracted while covered under these benefits (including inlays and crowns to form abutments).

Replacement of or addition of teeth to an existing removable denture (full or partial) or fixed bridgework as follows:

1. replacement or addition of teeth is made necessary by the extraction of natural teeth which occurred while covered under this Plan;

2. replacement is necessary when an immediate temporary denture was inserted shortly following extraction of teeth and cannot be economically modified to the final shape required;

3. the existing denture or bridgework was installed at least five years prior to its replacement and the existing denture or bridgework cannot be made serviceable.

Covered Orthodontia Services (available only to dependent children who are age 18 or less as of the date treatment commences)

Installations of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and conditions resulting from that malocclusion through correction of abnormally positioned teeth.

Diagnostic services, including examination, study models, radiographs and all other diagnostic aids used to determine orthodontic needs only once in any five (5) year period, commencing with the date of the initial visit.

Active orthodontic treatment for thirty-six (36) consecutive months or less. Retention treatment for eighteen (18) consecutive months or less.

If active or retention orthodontia treatment began prior to the date of coverage, the maximum number of months for which benefits will be provided will be reduced by the number of months during which treatment was rendered prior to the date of coverage. Covered expenses will be the monthly fee which had been determined by the physician at the time the charges were incurred.

LIMITATIONS APPLICABLE TO DENTAL BENEFITS. Benefits are not payable for:

1. Replacement of defective or lost crown inserted while covered until 5 years have elapsed from the date of insertion.

2. Temporary crowns or gold foil restorations.

3. Appliance replacement performed less than 5 years after a placement or replacement which was performed while covered, except as specified.

4. Replacement at any time of dentures or bridges which can be made serviceable.

5. Denture adjustments during the first 6 months following denture placement performed by the same or associated Physician who provided or repaired the appliance.

6. Appliances or restorations necessary to increase vertical dimensions and/or restore the occlusion.

7. 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.

8. Tooth implants.

9. Personalizing dental service by added restorations to artificial teeth, implant dentures, use of magnets, or similar procedures.

10. Charges incurred for dental services which were ordered or started before coverage began, including but not limited to the installation, manufacture or fitting of dental restorations (fillings, inlays, crowns, bridgework and dentures).

11. Expenses related to services or supplies of the type normally intended for sport or home use.

12. Charges for replacement of bridges or dentures lost, misplaced or stolen.

13. Splinting for periodontal purposes and/or other appliances or restorations whose primary purpose is to stabilize periodontally involved teeth.

14. Treatment of Temporomandibular Joint Dysfunction Syndrome (including all myofacial pain syndromes and other associated disorders).

15. Replacement and/or repair of any appliance used during the course of orthodontia treatment.

16. Orthodontia treatment rendered within 5 years after the completion of a course of orthodontia treatment.

SECTION 13 -- GENERAL EXCLUSIONS

No payment will be made under this Plan in any event for the following:

Any treatment or service not prescribed by a Physician.

Any treatment or service resulting from Sickness or Injury which is covered by a Workers' Compensation Act or other similar legislation; or due to Injury or Sickness incurred as the result of, or in the course of, any employment for wage or profit.

Any treatment or service resulting from war or any act of war, declared or undeclared, or participation in insurrection or riot or participation in commission of an assault or felony.

Any expenses where there is no legal obligation or financial liability to pay, or where charges would not be made if there were no coverage under this Plan (except where required by law).

Education or training.

Any treatment or service rendered by a member of the immediate family (employee, spouse, child, brother, sister, or parent of the Covered Person or his spouse).

Any loss caused by intentionally self-inflicted injuries or suicide, while sane or insane.

Any treatment or service which is covered by no-fault (automobile) state provisions or other similar legislation.

Services or supplies which are not necessary.

Charges for failure to keep a scheduled visit or charges for completion of a claim form.

Personal hygiene, comfort or convenience items.

Charges which exceed Reasonable and Customary.

Services or supplies received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustees, or similar person or group.

Any treatment or service which is compensated for or furnished by the local, state or federal government (except where required by law).

Drugs, medical supplies, medical devices, medical equipment, medical or surgical procedures, treatments or services which are Experimental and/or Investigational or do not meet accepted standards of medical practice. A drug, device, treatment, or procedure is considered to be Experimental and/or Investigational:

1. If the device, drug, treatment or procedure has not received the approval or endorsement of the American Medical Association (AMA), U.S. Food and Drug Administration (FDA) or the National Institute of Health (NIH) at the time the device, drug or procedure was furnished; or

2. If reliable evidence demonstrates that the device, drug, treatment or procedure is the subject of ongoing Phase I, II or III Clinical Trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment or diagnosis; or

3. If reliable evidence demonstrates that a consensus of opinion among medical experts regarding the device, drug, treatment or procedure is that further studies or Clinical Trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

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

NORTHWEST SUBURBAN SPECIAL EDUCATION ORGANIZATION

(NSSEO)

DENTAL PLAN DOCUMENT

This Plan Document has been prepared for review by the undersigned Client and its legal counsel.

Each provision, each benefit, each page in this Plan Document for which the pages are dated January 1, 2000 has been reviewed and approved by the undersigned.

Any changes in this Document shall be made by written Amendment.

Client Name: Northwest Suburban Special Education Organization (NSSEO)

Approved By: _____

Date: 12/21/99

/1st COMMONWEALTH

Dental HMO Benefit Summary

Northwest Suburban Special Education Organization

Subscription Certificate & Evidence of Coverage

Your Dental Plan & How To Use It

FIRST COMMONWEALTH

A Wholly Owned Subsidiary of Guardian

GG-014276

The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.

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Welcome to First Commonwealth

We at First Commonwealth are pleased that you have become a member of our dental plan. We encourage you to maintain your oral health by visiting your participating General Dentist on a regular basis.

To assist you in using your dental care coverage, we have made this booklet available to you. Please review it carefully and keep it with your other important documents. This booklet is issued in conjunction with a Group Master Policy which contains other details regarding your coverage. Your Group maintains a copy of the Group Master Policy. You may inspect it at any time at the Group's office during their normal business hours or, if you prefer you may contact First Commonwealth.

First Commonwealth
550 West Jackson Blvd., Suite 800
Chicago, IL 60661
Member Services: (866) 494-4542
www.firstcommonwealth.net

For Your Information

By acceptance of coverage under the terms of the Group Master Policy, Subscriber authorizes every provider rendering services hereunder to disclose all treatment facts pertaining to Subscriber and Dependents to us upon request.

Furthermore, you as the Subscriber represent to the best of your knowledge or information that information contained in any applications, forms or statements submitted to First Commonwealth shall be true, correct and complete and all rights to Plan Benefits are subject to the condition that all such information shall be true, correct and complete.

Please be aware that all rights of you and your enrolled Dependents to receive Plan Benefits are personal and may not be assigned to anyone else.

For Assistance Call (866) 494-4542

Our specially trained Member Services Representatives are available Monday through Friday, from 8:00 am to 7:00 pm (CST) to assist you. They can answer any questions you may have regarding how your dental plan works, assist in selecting or changing a General Dentist, assist in status changes and handle any inquiries or complaints you may have.

Your Effective Date of Coverage and Eligibility

Your Group determines the effective date of your coverage and who is eligible to participate. This is specified in the Group Application.

As the Subscriber, you may enroll yourself alone, or together with your spouse and/or eligible dependent children (subject to age limits under your Group's program). If you do not enroll your Dependent(s) on the date you enroll, you must wait to add them until the next Open Enrollment.

Dependents may be added, deleted, or you may change your coverage status on the date of the qualifying event, provided that First Commonwealth is notified in writing at least thirty one (31) days after the date of the qualifying event.

Children that are newly acquired Dependents through adoption or children placed for adoption may be enrolled on the date of the qualifying event, if First Commonwealth is given written notice within sixty (60) days of the qualifying event.

Qualifying Events

1. Marriage
2. Birth
3. Adoption
4. Children Placed for Adoption
5. Becoming a legal guardian of a child
6. Divorce
7. Death

Enrollment/Eligibility Period

Your enrollment in this Plan is for a minimum of twelve (12) consecutive months while eligible through your Group. Enrollment into this Plan or voluntary termination from this Plan will only be allowed during Open Enrollment periods which are determined by your Group and First Commonwealth. Persons not enrolled when first eligible may be enrolled only during your Group's next Open Enrollment period.

Choice of Participating Dental HMO Offices

You and your Dependents must select a participating General Dentist from the directory of General Dentists. Each member of your family may select a different dental location from the directory. Each dental office is privately owned and establishes their own policies, procedures and hours.

In order to obtain Plan Benefits, you must select a Participating Dental HMO Dentist and receive care from that dentist**. Care rendered by a non-participating dentist, or care rendered by a Specialist without obtaining prior written authorization for such care, is not a Plan Benefit.**

Dental HMO Quality Assessment

Participating General Dentists and Specialists must meet certain standards prior to acceptance in our network. Availability, access to care, license standing, professional liability insurance coverage, emergency care provisions, National Practitioner Data Bank ("NPDB") reports and State Board ("BODEX") histories are some of the factors considered in reviewing an application.

First Commonwealth periodically reviews the care provided through a peer review process. If you have any questions or concerns about the care you are receiving, you are encouraged to review them first with your Participating General Dentist or Specialist. Our Member Services Department is also available to answer any questions you may have or to discuss any concern you may have.

Changing Your Dental Office Selection

You may change your participating dental office at any time during the benefit year. A change can be made by calling our Member Services Department (866) 494-4542 with the change information. If First Commonwealth is notified by the 15th of the month the change will be effective the first of the following month. If you notify First Commonwealth after the 15th of the month, the change will be effective the first day of the second month following your request. You may call your new dental office to schedule an appointment after your request for a change has become effective.

Specialty Care Referrals

Certain Plan Benefits require the services of a specialist (i.e. some oral surgery, orthodontics, endodontics, periodontics and pedodontics). In those cases, your dental HMO general dentist will refer you to a participating specialist. **You will be provided with a copy of the referral form to present to the specialist at the time of your appointment.**

How To Make An Appointment

You may schedule appointments with your General Dentist by calling the selected office **after your effective date of coverage.** When you call to schedule your appointment, notify the office that you are a member of First Commonwealth's dental plan. Be aware that you, like all other patients at your dentist's office, may need to wait longer for appointments at peak times (e.g. evenings, weekends). If you are flexible on time and days, you should generally expect to receive a routine appointment within several weeks of calling.

Appointments You Cancel

The time set aside for you is very valuable to your dentist. **Therefore, if you cannot keep an appointment, notify the dental office at least 24 hours in advance.** A charge may be assessed for broken appointments with less than 24 hours notice. Frequent broken appointments can result in your inability to establish and maintain a satisfactory dentist-patient relationship and thereby jeopardize our ability to provide you with ongoing coverage.

Emergency Care

Emergency Care means the provision of dental care for the sudden and, at the time, unexpected onset of a dental condition which would lead a prudent layperson to believe that failure to receive immediate dental care would result in a serious problem to the teeth or would place the person's oral health in serious jeopardy.

In Area Emergency Care: If you are in the plan service area and need Emergency Care, you should call your General Dentist. All General Dentists are required to have arrangements for 24-hour Emergency Care. If your General Dentist is unable to make arrangements for Emergency Care, you should call our Member Services Department. If you are unable to reach First Commonwealth(e.g. you are calling during non-business hours), you should seek care from any licensed dentist to alleviate the emergency condition only.

Out of Area Emergency Care: If you are more than fifty miles from your General Dentist and need Emergency Care, you should seek care from any licensed dentist to alleviate the emergency condition only.

If you receive Emergency Care out of network: You must call First Commonwealth's Member Services Department within seventy-two (72) hours after Emergency Care is provided to you by a non- participating dentist. The Member Services Representative will direct you to submit the dentist's bill listing the Emergency Care services to First Commonwealth within thirty days. Upon review, you will be reimbursed within thirty days of First Commonwealth's receipt of all information relevant to your Emergency Care less any applicable Copayment. Your reimbursement will be in accordance with plan benefits needed for the relief of acute pain, swelling or trauma.

Follow-up Care: Follow-up care, if needed, should be rendered by your General Dentist.

Identification Cards

You will receive an identification card (one per household per provider selected). It identifies you as the Subscriber eligible for services and lists the number of family Dependents registered at the selected dental office. The identification card also contains the phone number for you to call to schedule an appointment or Emergency Care with your dentist.

The identification card serves as a reminder of the Plan Benefits under which you are enrolled and the Participating Dental HMO Office you have selected. **You do not need the card to schedule an appointment nor do you need more than one card per family.** The card is only issued for your convenience, and is not a guarantee of coverage.

The identification card contains the First Commonwealth Member Services Department phone number and the address to send any Emergency Care claim forms or other correspondence to First Commonwealth.

Your Payment Responsibilities (Copayment)

Copayments represent your portion of the total cost of Plan Benefits paid to the participating dental offices. You and your Dependents are responsible for paying the Copayment for the covered benefit at the time of service.

The coverage levels contained in the Schedule of Benefits section of this booklet are guaranteed under this contract. All coinsurance percentages are applied to an annual fee schedule that Participating Dental HMO offices have agreed to accept. Your portion of the cost, i.e., your Copayment is based on this fee schedule and will not vary, based on which Participating Dental HMO Office you choose or your dentist's customary charges for services rendered.

Compensation of Participating Dentist

A participating dentist receives a fixed payment for eligible members enrolled in the dentist's practice. Payment is made irrespective of the number of services rendered or eligible members seen. The total compensation that a participating dentist receives is equal to this fixed payment plus reimbursement for services actually rendered based on the annual fee schedule that participating dentists have agreed to accept.

Coordination of Benefits

The benefits of this dental plan may be coordinated with another dental plan according to the terms of your Group Master Policy.

Automatic Renewal of Coverage

Your coverage will automatically be renewed each year unless you notify your Group of your intent to terminate coverage no later than thirty-one days prior to the renewal date.

Refusing Treatment

A Member may decide to refuse a course of treatment recommended by their General Dentist or Specialist. Members can request and receive a second provider's opinion by contacting Member Services. If the recommended treatment is still refused, the General Dentist or Specialist will have no further responsibility to provide services for the condition involved and the Member may be required to select another General Dentist or Specialist.

Termination of Coverage

Plan Benefits may be terminated immediately for any of the following reasons:

1. Termination of the Group Master Policy.
2. Your (or your eligible enrolled Dependents) failure to meet the eligibility requirements.
3. A Member's failure to pay applicable Copayments when due.
4. Material misrepresentation (fraud) in obtaining coverage.
5. Permitting the use of your identification card by another person, or using another person's identification card to obtain care to which one is not entitled.
6. Failure to establish a satisfactory dentist/patient relationship with a First Commonwealth Dental HMO Dentist.
7. Failure of Group or individual member (if applicable) to pay a Premium in a timely manner.

Coverage for a Subscriber and his/her Dependents will terminate according to the terms of the Group Master Policy, except for any of the reasons (1- 7) above when termination is immediate. In the event coverage is terminated, the Member shall become liable for charges resulting from treatment received after termination.

Complaint Resolution Procedures

We, our staff, and affiliated dental HMO dentists are committed to providing quality dental services in a convenient and accessible fashion. It is our commitment to do that in a manner which continually meets our Members' expectations. The Complaint Resolution Procedure is as follows:

If you have questions, concerns, comments or complaints about services, personnel or facilities that cannot be resolved to your satisfaction after speaking directly with the dentist or other concerned party, please contact us in writing or by phone. Our internal service standards require, where possible, to resolve all Member's inquiries and concerns immediately. If however resolving the issue will require additional time, the Member will be given the best estimate of the amount of time needed for resolution.

If your complaint has not been resolved to your satisfaction, you have the right to appeal our decision. You may do so by submitting, in writing, the reasons why you disagree with our decision along with any additional information you wish us to consider. This appeal should be submitted no later than 30 days from the date of our original decision or from the date of the incident. You will receive an acknowledgement of our receipt of the appeal advising you of when to expect a written response.

The appeal will then be sent to the President for a final review and decision. The President, at his sole discretion, may advise you of a hearing date to review the complaint and consider all the facts. You must attend the hearing (up to three dates will be considered). If following the outcome of the appeal process you are still dissatisfied with the resolution, you may choose to notify the State of Illinois Department of Insurance at:

Consumer Service Department
Illinois Department of Insurance
320 West Washington
Springfield, IL 62767
or
Illinois Department of Insurance
100 West Randolph, Suite 15-100
Chicago, IL 60601-3251

Definitions

Copayment means your portion of the cost of services rendered that you pay the dentist directly at the time services are performed. Your copayment is based on a fee schedule that all participating dentists have agreed to accept and the applicable coinsurance rate determined from the Schedule of Benefits. Copayments are adjusted on January 1st each year based on adjustments in the fee schedule accepted by participating providers. All providers charge the same copayments (for the same services) based on the fee schedule in effect at the time services are rendered.

Dependent means your spouse (unless legally separated) and/or unmarried children up to the age of 19. Eligible children include natural or adopted children, children placed for adoption, stepchildren, and foster children for whom you or your spouse are the legal guardian. Eligibility may be extended up to the age of 23 to any of your children who are registered students in full-time attendance at an accredited school, college, or university. Eligibility will also be extended to any child past the age of 19 who is handicapped and dependent on you for support.

Emergency Care means the provision of dental care for the sudden and, at the time, unexpected onset of a dental condition which would lead a prudent layperson to believe that failure to receive immediate dental care would result in a serious problem to the teeth or would place the person's oral health in serious jeopardy.

Exclusion means any service which is not a Plan Benefit.

First Commonwealth means First Commonwealth Insurance Corporation, an Illinois domiciled Life, Accident and Health Insurance Company that is also licensed as a limited health services organization. First Commonwealth has entered into a Group Master Policy with your Group to provide eligible subscribers and dependents with the Plan Benefits described in this booklet.

General Dentist means a Participating Dental HMO general dentist that the Member selects from the dental HMO participating dentist list to provide or arrange for all dental care needs.

Group means your employer, labor union, trust, association, partnership, or other organization to which we issue a Group Master Policy, and through which you have become entitled to the Plan Benefits described in this brochure.

Group Master Policy means the contract issued to the Group that contains all the provisions of coverage.

Limitation means any restriction on a Plan Benefit.

Member means you or a covered dependent who is actually enrolled in the plan.

Participating Dental HMO Dentist means a general or specialty dentist who is under contract to First Commonwealth of Illinois, Inc., a Preferred Provider Administrator registered with the Illinois Department of Insurance. First Commonwealth of Illinois, Inc., through its contracts with dentists, arranges for all covered dental services pursuant to its contract with First Commonwealth and on file with the Illinois Department of Insurance. Participating dental HMO providers shall include any hygienists and technicians recognized under Illinois law to act with and assist the dentist.

Plan Benefit means those specific dental benefits and charges covered by us and described in this booklet.

Premium means the amount you the Subscriber, or by the Group (on your behalf), pays to us to maintain coverage according to the terms of the Group Master Policy. You agree to have any required contribution towards premium be collected by the Group and remitted to us.

Service Area means the geographic area in which we provide our dental HMO Plan Benefits.

Specialist means a Participating Dental HMO dentist who has satisfied the additional training requirements in a specific area of dentistry and obtained a separate license to practice in that specialty area. Examples of dental specialists include Oral Surgeons, Endodontists (root canals), Periodontists (gum surgery), Orthodontists (braces) and Pedodontists (special needs of children).

Subscriber means you, the eligible person from the Group that enrolls in the benefit plan.

SCHEDULE OF BENEFITS - PLAN 7000

The coverage shown below is applied to the First Commonwealth fee schedule that is in effect in your area from January 1st to December 31st each year. For services covered at 100%, you pay nothing except any applicable office visit copayment. For services covered at less than 100%, your Payment Responsibility is based on the First Commonwealth fee schedule in effect at that time and any applicable office visit copayment. A current schedule listing your Payment Responsibility for each covered service is available through your Group or by calling Member Services.

Office Visit Copayment: There is a $0 office visit copayment due each time you visit your participating Dental HMO Dentist.

Type of Service	Plan Covers

PREVENTIVE & DIAGNOSTIC SERVICES

Oral Examinations **100%**

Initial, Periodic, Emergency & Limited Exams, Detailed & Extensive Oral Evaluation

X-Rays **100%**

Intraoral, Periapical, Occlusal, Bitewing & Panoramic

Other Diagnostic Services **100%**

Diagnostic Casts, Caries Indicators, Pulp Vitality Tests

Routine Preventive Services **100%**

Prophylaxis (cleaning), Fluoride Application, Nutritional Counseling, Oral Hygiene Instruction, Sealants

MINOR SERVICES

Minor Restorative **85%**

Amalgams, Anterior Direct Composite Resins, Sedative Fillings, Recementation of Crown & Inlays

Endodontics **85%**

Root Canal Therapy, Pulp Capping, Retrograde Filling, Pulpotomies, Apicoectomies, Apexification, Root Amputation, Hemisection, Canal Preparation for Posts, Pulpal Therapy

Periodontics **85%**

Gingival & Osseous Surgery, Gingival Flap Procedure, Gingivectomy, Bone & Tissue Grafts, Distal or Proximal Wedge, Crown Lengthening, Periodontal Maintenance Procedures, Periodontal Scaling & Root Planing, Gingival Curettage, Full Mouth Debridement

Oral Surgery **85%**

Surgical Extractions of Impacted Teeth, Alveoplasties, Frenectomies, Surgical Exposure to Aid Eruption, Removal of Residual Roots, Removal of Benign Odontogenic Cyst or Tumor

MAJOR SERVICES

Removable Dentures 80%

Complete, Immediate & Partial Dentures, Denture Adjustments Including Reline, Rebase & Repairs, Tissue Conditioning

Crown & Fixed Bridges 80%

Inlays & Onlays (indirect laboratory fabricated metallic, resin & ceramic) & Crowns (indirect laboratory fabricated metallic, metallic/ceramic, metallic/resin), Pin Retention, Post & Core, Core Build-Ups, Repairs of Crown & Bridgework, Pre-Fabricated Crowns

OTHER SERVICES

Local Anesthesia 100%

Miscellaneous 85%

Space Maintainers, Occlusal Adjustments, Consultation, Desensitizing Medicaments, Treatment for Temporary Relief of Pain (emergency)

Cosmetic 50%

Labial Veneers

General Anesthesia 50%

For Oral Surgery When Medically Necessary

ORTHODONTICS

Class I or II Malocclusion . . . . . $1,000 savings*

* Your Payment Responsibility for Orthodontic Services is based on the First Commonwealth fee schedule in effect at the time treatment is initiated. Your Payment Responsibility represents a $1,000 savings off the prevailing orthodontic fees in the community.

Procedures, services, or treatment not specifically listed in this Schedule of Benefits are excluded. Any non-covered service may be rendered by a General Dentist or Specialist for the usual fee upon agreement by the dentist and Member. Payment for non-covered services will be the sole responsibility of the Member.

Limitations

All time Limitations are determined from the date that service was last rendered.

1. Bitewing radiographs are covered every six (6) months, not to exceed twice in any calendar year. Full mouth radiographs (periapical series with bitewings or panoramic) are covered once every thirty-six (36) months.
2. Routine oral evaluations, prophylaxis, and fluoride treatments are covered once every six (6) months, not to exceed twice in any calendar year.
3. Sealants may only be applied to permanent posterior teeth for children through age 16 and are limited to one treatment every eighteen (18) months.
4. Periodontal scaling and root planing is covered once every twelve (12) months.
5. Periodontal maintenance procedures are covered once every six (6) months, not to exceed twice in any calendar year.
6. Denture relines will be limited to one (1) under this Plan every three (3) years.
7. Crowns, fixed bridgework, and/or removable prosthetic appliances, other than stainless steel crowns, are covered after five (5) years have elapsed from any prior placement, unless the prosthetic appliance becomes unsatisfactory due to illness, significant changes in the oral condition, or other causes not controlled by ordinary circumstances.
8. Crowns and inlays (cast restorations) are covered only if there is insufficient tooth structure to retain a direct filling.
9. When the Member is missing more than four (4) functionally unrestored teeth in an arch (excluding third molars), the replacement of these missing teeth with fixed bridgework is not covered.
10. This Plan provides for crowns, fixed bridgework, and removable prosthetic appliances using standard materials and procedures. The Member will be responsible for any additional charges resulting from any optional materials and/or procedures, including but not limited to:
    a. High noble metal (gold) used in fixed or removable restorations/prosthetic appliances
    b. Precision attachments/partials
    c. Over dentures
    d. Implants (placement or removal)
    e. Personalization, customization, or characterization of any fixed or removable prosthetic appliance.
11. Use of nitrous oxide analgesia is at the discretion of the dentist and may not be available at all locations.
12. General anesthesia is limited to professional fees only, in instances where the health of the patient would be compromised if not administered and the patient requires a covered oral surgical service. Documentation from a medical physician must be provided in advance and all cases must be pre-approved by First Commonwealth. Patient comfort, convenience, or anxiety alone are not conditions for which general anesthesia will be covered.
13. Referrals for pedodontic specialty care are limited to:
    a. Children through age five (5) for behavioral management issues, or
    b. Children through age twelve (12) with severe or unusual dental problems or who are otherwise disabled, who, in the opinion of the First Commonwealth Dental Director, require the expertise of a specialist.

Exclusions

Your First Commonwealth plan does not provide coverage for the following:

1. Services rendered by other than the Member's Participating General Dentist and/or Specialist.
2. Dental services not listed on the Schedule of Benefits.
3. Charges for the use of any facility, equipment, and/or supplies provided outside the Participating Dental HMO Office.
4. Treatment in progress at the inception of this Plan, or dental treatment and expenses incurred prior to the Member's eligibility to receive Plan Benefits under this Plan, or after the termination of the Member's coverage.
5. Dental services rendered specifically for cosmetic purposes, except as may be indicated on the Schedule of Benefits.
6. Procedures, appliances, or restorations (including orthodontic treatment) to correct congenital or developmental malformations, including anodontia.
7. Plan Benefits are limited to procedures necessary to eliminate oral disease and replace missing natural teeth. Procedures, appliances, or restorations (other than fillings) that are necessary as part of full mouth reconstruction are not covered, including, but not limited to:
   a. Increasing vertical dimension
   b. Periodontal splinting
   c. Gnathologic recordings
   d. Equilibration
   e. Treatment of TMJ disturbances or disorders
   f. Realignment of teeth
   g. Replacing or stabilizing tooth structure loss due to attrition
   h. Orthodontic treatment
8. Experimental dental, surgical, or health care procedures.
9. Dental services which, in the opinion of the Participating General Dentist or Specialist, will not achieve a satisfactory result, cannot be performed because of the general health or physical limitations of the Member, or which are not normally indicated for the treatment of dental disease.
10. Duplication of any appliance or replacement of fixed or removable prosthetic restorations or appliances due to loss, theft, or damage.
11. Failure of prosthodontic, orthodontic, or any other appliances or services due to abuse and/or neglect by the Member.
12. Dental implant procedures and related dental services, including crowns and/or fixed bridgework supported by implants.
13. Interim crowns, bridges or dentures not incidental to an ongoing course of treatment.
14. Services which are covered under other non-dental insurance plans, which are covered through Worker's Compensation or Employer Liability Laws or for which coverage exists through any municipality, county, military or other political entity or which are covered by any medical policy. This Plan does not duplicate coverage for Dental services.
15. Treatment for or removal of malignancies, neoplasms, cysts, or genetic malformations, except as specifically listed on the Schedule of Benefits.
16. Diagnosis and services and/or procedures related to the treatment of temporomandibular joint (TMJ)-related disturbances/disorders.
17. Preventive control programs, including but not limited to, soft tissue management program.
18. Expenses relating to dental health record duplication and transfers.

19. The following Orthodontic services are excluded:
    a. Lingual or clear bands/brackets
    b. Interceptive orthodontic appliances and treatment
    c. Replacement of appliances due to theft, loss, or breakage
    d. Retreatment of orthodontic cases
    e. Treatment in progress at inception of eligibility
    f. Changes in treatment necessitated by an accident
    g. Orthodontic treatment that involves:
        i. maxillofacial surgery
        ii. myofunctional therapy
        iii. cleft palate
        iv. micrognathia
        v. macroglossia
        vi. hormonal imbalances causing growth and development abnormalities
        vii. treatment related to temporo-mandibular joint disturbances/ disorders

Orthodontic treatment is limited to one full course of twenty-four (24) continuous months of active treatment under this Plan using conventional metal bands/brackets.

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

Insured employees and their dependents can access helpful, secure information about their Guardian benefits(s) online at:

GuardianAnytime.com - 24 hours a day, 7 days a week.

Anytime, anywhere you have an internet connection you will be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of a claim
- Print forms and plan materials
- And so much more]

To register, go to www.GuardianAnytime.com

Building a promising future for students

NSSEO

Northwest Suburban Special Education Organization

Life Insurance Policies

RELIANCE STANDARD
Life Insurance Company

Home Office: Chicago, Illinois • Administrative Office: Philadelphia, Pennsylvania

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CERTIFICATE OF INSURANCE

We certify that you (provided you belong to a class described on the Schedule of Benefits) are insured, for the benefits which apply to your class, under Group Policy No. GL 645971 issued to Northwest Suburban Special Education Organization, the Policyholder.

When loss of life covered under the Policy occurs, we will pay the amount stated on the Schedule of Benefits to the named beneficiary, subject to provisions entitled Beneficiary and Facility of Payment.

This Certificate is not a contract of insurance. It contains only the major terms of insurance coverage and payment of benefits under the Policy. It replaces all certificates that may have been issued to you earlier.

Secretary

President

GROUP LIFE INSURANCE CERTIFICATE

This Group Life Certificate replaces any previous Group Life Certificates and is dated October 14, 2009.

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SCHEDULE OF BENEFITS

EFFECTIVE DATE: January 1, 2009

ELIGIBLE CLASSES: Each active, Full-Time Employee under NSSEA Contract, Social Worker, or School Psychologist, except any person employed on a temporary or seasonal basis.

WAITING PERIOD: 30 days of continuous employment.

INDIVIDUAL EFFECTIVE DATE: The day immediately following completion of the Waiting Period.

INDIVIDUAL REINSTATEMENT: 6 months

AMOUNT OF INSURANCE:

Basic Life and Accidental Death and Dismemberment: One (1) times Earnings, rounded to the next higher $1,000, subject to a maximum of $150,000.

For Insureds age 65 and over, the Amount of Basic Life and Accidental Death and Dismemberment Insurance is subject to automatic reduction. Upon the Insured's attainment of the specified age below, the Amount of Basic Life and Accidental Death and Dismemberment Insurance will be reduced to the applicable percentage. This reduction also applies to Insureds who are age 65 or over on their Individual Effective Date.

Age	Percentage of available or in force amount at age 65
65-69	65%
70+	50%

The Life amount will be reduced by any benefit paid under the Accelerated Benefit Rider.

CHANGES IN AMOUNT OF INSURANCE: Increases and decreases in the Amount of Insurance because of changes in age, class or earnings (if applicable) are effective on the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively At Work on the date of the change. If you are not Actively At Work when the change should take effect, the change will take effect on the day after you have been Actively At Work for one full day.

CONTRIBUTIONS: You are not required to contribute toward the cost of the Basic Insurance.

DEFINITIONS

"We," "us" and "our" means Reliance Standard Life Insurance Company.

"You," "your" and "yours" means a person who meets the eligibility requirements of the Policy and is enrolled for this insurance.

"Actively at work" and "active work" means actually performing on a Full-time basis each and every duty pertaining to your job in the place where and the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave, but does not include time off as a result of injury or illness.

"Full-time" means working for the Policyholder for a minimum of 31 hours during your regularly scheduled work week.

"The date you retire" or "retirement" means the effective date of your:

(1) retirement pension benefits under any plan of a federal, state, county or municipal retirement system, if such pension benefits include any credit for employment with the Policyholder;
(2) retirement pension benefits under any plan which the Policyholder sponsors, or makes or has made contributions;
(3) retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act.

"Earnings", as used in the SCHEDULE OF BENEFITS section, means your annual salary received from the Policyholder on the day just before the date of loss, prior to any deductions to a 401(k) or Section 125 plan. Earnings does not include commissions, overtime pay, bonuses or any other special compensation not received as basic salary.

If hourly employees are insured, the number of hours worked during a regularly scheduled work week, not to exceed forty (40) hours per week, times fifty-two (52) weeks, will be used to determine annual earnings.

"Total Disability" as used in the WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY section, means your complete inability to engage in any type of work for wage or profit for which you are suited by education, training or experience.

"Loss" as used in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section, with respect to:

(1) hand or foot, means the complete severance through or above the wrist or ankle joint;

(2) the eye, speech or hearing, means total and irrecoverable loss thereof.

"Injury" means accidental bodily injury which is caused directly by accidental means and which occurs while your coverage under the Policy is in force.

GENERAL PROVISIONS

INCONTESTABILITY

Any statements made by you, or on your behalf to persuade us to provide coverage, will be deemed a representation, not a warranty. This provision limits our use of these statements in contesting the amount of insurance for which you are covered. The following rules apply to each statement:

(1) No statement will be used in a contest unless:

(a) it is in a written form signed by you, or on your behalf; and

(b) a copy of such written instrument is or has been furnished to you, your beneficiary or legal representative.

(2) If the statement relates to your insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two (2) years during your lifetime.

ASSIGNMENT

Ownership of any benefit provided under the Policy may be transferred by assignment. An irrevocable beneficiary must give written consent to assign this insurance. Written request for assignment must be made in duplicate at our Administrative Offices. Once recorded by us, an assignment will take effect on the date it was signed. We are not liable for any action we take before the assignment is recorded.

EFFECTIVE DATE AND TERMINATION

EFFECTIVE DATE OF INSURANCE: If the Policyholder pays the entire premium, your insurance will go into effect on the date stated on the Schedule of Benefits. If you pay a part of the premium, you must apply in writing for the insurance to go into effect. You will become insured on the date stated on the Schedule of Benefits, except that the insurance will go into effect:

(1) on the date you apply, if you apply within thirty-one (31) days of the date you are first eligible; or

(2) on the date we approve any required proof of good health. We require proof of good health if you apply:

(a) after thirty-one (31) days from the date you first become eligible; or

(b) after you terminated this insurance but remained in a class eligible for this insurance.

Changes in your amount of insurance are effective as shown on the Schedule of Benefits.

If you are not actively at work on the day your insurance is to go into effect, the insurance will go into effect on the day you return to active work for one full day.

TERMINATION OF INSURANCE: Your insurance will terminate on the first of the following to occur:

(1) the date the Policy terminates; or

(2) the last day of the Policy month in which you cease to be in a class eligible for this insurance; or

(3) the end of the period for which premium has been paid for you; or

(4) the date you enter military service (not including Reserve or National Guard).

CONTINUATION OF INSURANCE: Your insurance may be continued by payment of premium beyond the date you cease to be eligible for this insurance, but not longer than:

(1) twelve (12) months, if due to illness or injury; or

(2) one (1) month, if due to temporary lay-off; or

(3) twenty-four (24) months, if due to approved leave of absence.

REINSTATEMENT: Your insurance may be reinstated if it was terminated while you were:

(1) on an approved leave of absence, or

(2) on a temporary lay-off.

You must return to active work within the period of time shown on the Schedule of Benefits. You must also be a member of a class eligible for this insurance.

You will not be required to fulfill the eligibility requirements of the Policy again. The insurance will go into effect on the day you return to active work. If you return after having resigned or having been discharged, you will be required to fulfill the eligibility requirements of the Policy again.

If you return after terminating at your own request or for failure to pay premium when due, proof of good health must be approved by us before you may be reinstated.

CONVERSION PRIVILEGE

You can use this privilege when your insurance is no longer in force. It has several parts. They are:

A. If the insurance ceases due to termination of employment or membership in any of the Policy's classes, an individual Life Insurance Policy may be issued. You are entitled to a policy without disability or supplemental benefits. You must make written application for the policy within thirty-one (31) days after you terminate. The first premium must also be paid within that time. The issuance of the policy is subject to the following conditions:

   (1) The policy will, at your option, be on any one of our forms, except for term life insurance. It will be the standard type issued by us for the age and amount applied for;

   (2) The policy issued will be for an amount not over what you had before you terminated;

   (3) The premium due for the policy will be at our usual rate. This rate will be based on the amount of insurance, class of risk and your age at date of policy issue; and

   (4) Proof of good health is not required.

B. If the insurance ceases due to the termination or amendment of the Policy, an individual Life Insurance Policy can be issued. You must have been insured for at least five (5) years under the Policy. The same rules as in A above will be used, except that the face amount will be the lesser of:

   (1) The amount of your Group Life benefit under the Policy. This amount will be less any amount you are entitled to under any group life policy issued by us or another insurance company; or

   (2) $10,000.

C. If the insurance reduces, as may be provided in the Policy, an individual Life Insurance Policy can be issued. The same rules as in A above will be used, except that the face amount will not be greater than the amount which ceased due to the reduction.

D. If you die during the time in which you are entitled to apply for an individual policy, we will pay the benefit under the Group Policy that you were entitled to convert. This will be done whether or not you applied for the individual policy.

E. Any policy issued with respect to A, B or C above will be put in force at the end of the thirty-one (31) day period in which application must be made.

F. If you are entitled to have an individual policy issued to you without proof of health, then you must be given notice of this right at least fifteen (15) days before the end of the period specified above. Such notice must be: (1) in writing; and (2) presented or mailed to you by the Policyholder. If not, you will have an additional period in order to do so. This additional period will end fifteen (15) days after you are given notice. This period will not extend beyond sixty (60) days after the expiration date of the period provided above. This insurance will not be continued beyond the period provided above.

BENEFICIARY AND FACILITY OF PAYMENT

BENEFICIARY: The beneficiary will be as named in writing by you to receive benefits at your death. This beneficiary designation must be on file with us or the Plan Administrator and will be effective on the date you sign it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

If you name more than one beneficiary to share the benefit, you must state the percentage of the benefit that is to be paid to each beneficiary. Otherwise, they will share the benefit equally.

The beneficiary's consent is not needed if you wish to change the designation. His/her consent is also not needed to make any changes in the Policy.

If the beneficiary dies at the same time as you, or within fifteen (15) days after your death but before we received written proof of your death, payment will be made as if you survived the beneficiary, unless noted otherwise.

If you have not named a beneficiary, or the named beneficiary is not surviving at your death, any benefits due shall be paid to the first of the following classes to survive you:

(1) your legal spouse;
(2) your surviving children (including legally adopted children), in equal shares;
(3) your surviving parents, in equal shares;
(4) your surviving siblings, in equal shares; or, if none of the above,
(5) your estate.

We will not be liable for any payment we have made in good faith.

FACILITY OF PAYMENT: If a beneficiary, in our opinion, cannot give a valid release (and no guardian has been appointed), we may pay the benefit to the person who has custody or is the main support of the beneficiary. Payment to a minor shall not exceed $1,000.

If you have not named a beneficiary, or the named beneficiary is not surviving at your death, we may pay up to $2,000 of the benefit to the person(s) who, in our opinion, have incurred expenses in connection with your last illness, death or burial.

The balance of the benefit, if any, will be held by us, until an individual or representative:

(1) is validly named; or
(2) is appointed to receive the proceeds; and
(3) can give valid release to us.

The benefit will be held with interest at a rate set by us.

We will not be liable for any payment we have made in good faith.

SETTLEMENT OPTIONS

You may elect a different way in which payment of the Amount of Insurance can be made. You must provide a written request to us, for our approval, at our Administrative Office. If the option covers less than the full amount due, we must be advised of what part is to be under an option. Amounts under $2,000 or option payments of less than $20.00 each are not eligible.

If no instructions for a settlement option are in effect at your death, the beneficiary may make the election, with our consent.

Settlement Options are described in the Policy.

WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY

We will extend the Amount of Insurance during a period of Total Disability for one (1) year if:

(1) you become totally disabled prior to age 60;
(2) the Total Disability begins while you are insured;
(3) the Total Disability begins while the Policy is in force;
(4) the Total Disability lasts for at least 9 months;
(5) the premium continues to be paid; and
(6) we receive proof of Total Disability within one (1) year from the date it began.

After proof of Total Disability is approved by us, neither you or the Policyholder is required to pay premiums. Also, any premiums paid from the start of the Total Disability will be returned.

We will ask you to submit annual proof of continued Total Disability. The Amount of Insurance may then be extended for additional one (1) year periods. You may be required to be examined by a Physician approved by us as part of the proof. We will not require you to be examined more than once a year after the insurance has been extended two (2) full years.

The Amount of Insurance extended will be limited to the amount of basic group life coverage on your life that was in force at the time that Total Disability began excluding any additional benefits. This amount will not increase. This amount will reduce or cease at any time it would reduce or cease if you had not been totally disabled. If you die, we will be liable under this extension only if written proof of death is received by us.

The Amount of Insurance extended for you will cease on the earliest of:

(1) the date you no longer meet the definition of Total Disability; or
(2) the date you refuse to be examined; or
(3) the date you fail to furnish the required proof of Total Disability; or
(4) the date you become age 70; or
(5) the date you retire.

You may use the conversion privilege when this extension ceases. Please refer to the Conversion Privilege section for rules. You are not entitled to conversion if you return to work and are again eligible for the insurance under the Policy. If you use the conversion privilege, benefits will not be payable under the Waiver of Premium in Event of Total Disability provision unless the converted policy is surrendered to us.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Nothing in this section will change or affect any of the terms of the Policy other than as specifically set out in this section. All the Policy provisions not in conflict with these provisions shall apply to this section.

If you suffer any one of the losses listed below, as a result of an injury, we will pay the benefit shown. The loss must be caused solely by an accident which occurs while you are insured, and must occur within 365 days of the accident. Only one benefit (the larger) will be paid for more than one loss resulting from any one accident. The Amount of Insurance can be found on the Schedule of Benefits.

LOSS OF:	**AMOUNT OF INSURANCE:**
Life	The Full Amount
Both Hands	The Full Amount
Both Feet	The Full Amount
The Sight of Both Eyes	The Full Amount
Speech and Hearing	The Full Amount
One Hand and One Foot	The Full Amount
One Hand and the Sight of One Eye	The Full Amount
One Foot and the Sight of One Eye	The Full Amount
One Hand	One-Half of the Amount
One Foot	One-Half of the Amount
Speech or Hearing	One-Half of the Amount
The Sight of One Eye	One-Half of the Amount

EXCLUSIONS

A benefit will not be payable for a loss:

(1) caused by suicide or intentionally self-inflicted injuries; or

(2) caused by or resulting from war or any act of war, declared or undeclared; or

(3) caused by sickness or disease; or

(4) sustained during your commission or attempted commission of an assault or felony; or

(5) caused by your acute or chronic alcoholic intoxication; or

(6) caused by your voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug.

SEAT BELT AND AIR BAG BENEFIT

Seat Belt Benefit

We will pay an additional Seat Belt Benefit if, due to an Injury sustained while driving or riding in a private passenger Four-Wheel Vehicle, you suffer loss of life for which an Accidental Death Benefit is payable under the Policy.

Once we receive the police accident report which confirms that you were properly strapped in a Seat Belt at the time of the accident, we will pay a benefit equal to 10% of the Accidental Death Benefit payable under the Policy.

If the police report does not clearly establish that you were or were not wearing a Seat Belt at the time of the accident which caused your death, the benefit payable will be $1,000 in lieu of the benefit described above.

“Seat Belt” means an unaltered factory-installed lap and/or shoulder restraint designed to keep a person steady in a seat.

Air Bag Benefit

In addition to the Seat Belt Benefit, we will also pay an Air Bag Benefit if such private passenger Four-Wheel Vehicle is equipped with a factory-installed Air Bag and the police accident report clearly establishes that you were positioned in a seat which is designed to be protected by an Air Bag and were properly strapped in the Seat Belt when the Air Bag inflated.

Once we receive the policy accident report which confirms that the Air Bag inflated properly upon impact, we will pay a benefit equal to 5% of the Accidental Death Benefit payable under the Policy.

“Air Bag” means an unaltered factory-installed supplemental restraint system designed to inflate upon impact to protect a person from bodily Injury during an accident.

“Four-Wheel Vehicle” means a private passenger automobile, a truck-type vehicle which has a manufacturer’s rated load capacity of 2,000 pounds or less, or a self-propelled motor home, all of which are registered for private passenger use and designated for transportation on public roadways.

Maximum Benefit Payable – The total combined maximum benefit payable under the Seat Belt and Air Bag Benefit is $25,000.

EXCLUSIONS

No benefit is payable for any loss sustained by you:

(1) if you were driving or riding in any private passenger Four-Wheel Vehicle which was being used in a race, speed or endurance test, or for acrobatic or stunt driving at the time of the accident;

(2) if you were not wearing a Seat Belt for any reason;

(3) while you were sharing a Seat Belt.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within 31 days after the Loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include your name and the Policy Number.

CLAIM FORMS: When we receive written notice of a claim, we will send claim forms to the claimant within 15 days. If we do not, the claimant will satisfy the requirements of written proof of loss by sending us written proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

PROOF OF LOSS: For any covered Loss, written proof must be sent to us within 90 days. If it is not reasonably possible to give proof within 90 days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within 1 year, unless the claimant is legally incapable of doing so.

PAYMENT OF CLAIMS: Payment will be made as soon as proper proof is received. All benefits will be paid to you, if living. Any benefits unpaid at the time of death, or due to death, will be paid to the beneficiary.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

PHYSICAL EXAMINATION: At our own expense, we will have the right to have you examined as reasonably necessary when a claim is pending. We can have an autopsy made unless prohibited by law.

LEGAL ACTION: No legal action may be brought against us to recover on the Policy within 60 days after written proof of loss has been given as required by the Policy. No action may be brought after three (3) years (Kansas, five (5) years; South Carolina and Michigan, six (6) years) from the time written proof of loss is required to be submitted.

FAMILY AND MEDICAL LEAVE OF ABSENCE EXTENSION

We will allow your coverage to continue for up to 12 weeks in a 12 month period, if you are eligible for, and the Policyholder has approved, a Family and Medical Leave of Absence under the terms of the Family and Medical Leave Act of 1993 for any of the following reasons:

(1) To provide care after the birth of a son or daughter; or
(2) To provide care for a son or daughter upon legal adoption; or
(3) To provide care after the placement of a foster child in your home; or
(4) To provide care to a spouse, son, daughter, or parent due to serious illness; or
(5) To take care of your own serious health condition as explained below.

If you, due to your own serious health condition, meet the definition of Total Disability in the Policy, you will be considered Totally Disabled and eligible for Waiver of Premium benefits according to the Waiver of Premium in Event of Total Disability provision. If you, due to your own serious health condition, are on a Family and Medical Leave of Absence, but not eligible for Waiver of Premium benefits under the Policy, insurance coverage will be continued under this extension.

You will not qualify for the Family and Medical Leave of Absence Extension unless we have received proof from the Policyholder, in a form satisfactory to us, that you have been granted a leave under the terms of the Family and Medical Leave Act of 1993. Such proof: (1) must outline the terms of your leave; and (2) give the date the leave began; and (3) the date it is expected to end; and (4) must be received by us within thirty-one (31) days after a claim for benefits has been filed with us.

If the Policyholder grants you a Family and Medical Leave of Absence, the following applies to you:

(1) While you are on an approved Family and Medical Leave of Absence, the required premium must be paid according to the terms specified in the Policy to keep the insurance in force.

(2) Coverage will terminate for you if you do not return to work as scheduled according to the terms of your agreement with the Policyholder; however, you are eligible to convert your coverage under the Conversion Privilege. In no case will coverage be extended under this benefit beyond 12 weeks in a 12 month period. Insurance will not be terminated for you if you become Totally Disabled during the period of the leave and are eligible for Waiver of Premium benefits, if any, according to the terms of the Policy.

(3) This extension is not available if you convert your coverage under the Conversion Privilege.

(4) While you are on an approved Family and Medical Leave of Absence, you will be considered Actively at Work in all instances unless such leave is due to your own illness, injury, or disability. Changes such as revisions to coverage because of age, class or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective for you while you are not Actively at Work until such time you return to Active Work for one full day.

All other terms and conditions of the Policy will remain in force while you are on an approved Family and Medical Leave of Absence.

MILITARY SERVICES LEAVE OF ABSENCE COVERAGE

We will allow your coverage to continue for up to twelve (12) weeks in a twelve (12) month period, if you enter the military service of the United States. While you are on a Military Services Leave of Absence, the required premium must be paid according to the terms specified in the Policy to keep the insurance in force. Changes such as revisions to coverage because of age, class or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective for you until you have returned to work from Military Services Leave of Absence for one full day. All other terms and conditions of the Policy will remain in force during this continuation period. Your continued coverage will cease on the earliest of the following dates:

(1) the date the Policy terminates; or
(2) the date ending the last period for which any required premium was paid; or
(3) twelve (12) weeks from the date your continued coverage began.

The Policy, however, does not cover any loss which occurs while you are on active duty in the military service if such loss is caused by or arises out of such military service, including but not limited to war or act of war (whether declared or undeclared).

PORTABILITY

You may continue insurance coverage under the Policy if coverage would otherwise terminate because you cease to be an Eligible Person, for reasons other than the termination of the Policy, or your retirement, provided you:

(1) notify us in writing within thirty-one (31) days from the date you cease to be eligible; and
(2) remit the necessary premiums when due; and
(3) are not approved for extension of coverage under the Waiver of Premium in Event of Total Disability provision, if applicable; and
(4) have not been terminated under the Waiver of Premium in Event of Total Disability provision, if applicable; and
(5) have been covered for twelve (12) months under the Policy and/or the prior group life insurance policy.

Such coverage may be continued for a period of 2 years beginning on the date you are no longer an Eligible Person.

The amount of coverage available under the Portability provision will be the current amount of coverage you are insured for under the Policy on the last day you were Actively at Work. However, the amount of coverage will never be more than:

(1) the highest amount of life insurance available to Eligible Persons; or
(2) a total of $500,000 from all RSL group life and accidental death and dismemberment insurance combined, whichever is less.

The premium charged to continue coverage will be based on the prevailing rate charged to Insureds who choose to continue coverage under the Portability provision. Such premium will be billed directly to you on a quarterly, semi-annual or annual basis.

If your coverage under the Policy includes Accidental Death and Dismemberment, then such benefits may be continued under the Policy.

Insurance coverage continued under this provision for you will terminate on the first of the following to occur:

(1) the date the Policy terminates; or
(2) the end of the period for which premium has been paid; or
(3) the date you are covered under another group term life insurance policy; or
(4) at the end of the 2 year period; or
(5) at any time coverage would normally terminate according to the terms of the Policy had you continued to be an Eligible Person.

In addition, coverage will reduce at any time it would normally reduce according to the terms of the Policy had you continued to be an Eligible Person.

If insurance coverage terminates due to (1) or (4) above, it may be converted to an individual life insurance policy. The conversion will be subject to the terms and conditions set forth under the Conversion Privilege.

GROUP TERM LIFE INSURANCE ACCELERATED BENEFIT RIDER

THIS RIDER ADDS AN ACCELERATED BENEFIT PROVISION. RECEIPT OF THIS ACCELERATED BENEFIT WILL REDUCE THE DEATH BENEFIT AND MAY BE TAXABLE. IN ADDITION, RECEIPT OF THIS BENEFIT MAY AFFECT THE INSURED'S ELIGIBILITY FOR MEDICAID OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS. INSUREDS SHOULD SEEK ASSISTANCE FROM THEIR PERSONAL TAX ADVISOR.

Attached to Group Policy Number: GL 645971
Issued to Group Policyholder: Northwest Suburban Special Education Organization

This Rider is attached to and made a part of the Policy indicated above. Your Certificate is hereby amended, in consideration of the application for this coverage, by the addition of the following benefit. In this Rider, Reliance Standard Life Insurance Company will be referred to as “we", “us", “our".

DEFINITIONS: This section gives the meaning of terms used in this Rider. The Definitions of the Policy and Certificate also apply unless they conflict with Definitions given here.

"Certified" or "Certification" refers to a written statement, made by a Physician on a form provided by us, as to the Insured’s Terminal Illness.

"Certificate" means the document, issued to each Insured, which explains the terms of his coverage under the Group Life Insurance Policy.

"Death Benefit" means the insurance amount payable under the Certificate at death of the Insured. It does not include any amount that is only payable in the event of Accidental Death.

"Insured" means only a primary Insured. Dependents are not eligible for coverage under this Accelerated Benefit Rider.

"Physician" means a duly licensed practitioner, acting within the scope of his license, who is recognized by the law of the state in which diagnosis is received. The Physician may not be the Insured or a member of his immediate family.

"Policy" means the Group Life Insurance Policy issued to the Group Policyholder under which the Insured is covered.

"Terminally Ill" or "Terminal Illness" refers to an Insured’s illness or physical condition that is Certified by a Physician to reasonably be expected to result in death in less than 24 months.

"Written Request" means a request made, in writing, by the Insured to us.

All pronouns include either gender unless the context indicates otherwise.

DESCRIPTION OF COVERAGE: This benefit is payable to the Insured if, the Insured's coverage is in force and the Insured is Certified as Terminally Ill: at any time for loss resulting from accidental injury; or after having been insured under this Rider for at least 30 days prior to a loss resulting from sickness. In order for this benefit to be paid:

(1) the Insured must make a Written Request; and

(2) we must receive from any assignee or irrevocable beneficiary their signed acknowledgment and agreement to payment of this benefit.

We may, at our option, confirm the terminal diagnosis with a second medical exam performed at our own expense.

AMOUNT OF THE ACCELERATED BENEFIT: The Accelerated Benefit will be an amount equal to 75% of the Death Benefit applicable to the Insured under the Policy on the date of the Certification of Terminal Illness, subject to a maximum benefit of $500,000. This benefit may be paid as a single lump sum or in installment payments mutually agreed to by us and the Insured. The Accelerated Benefit is payable one time only for any Insured under this Rider.

EFFECT OF BENEFIT: If an Insured becomes eligible for, and elects to receive this benefit, it will have the following effects:

(1) The Death Benefit payable for such Insured will be reduced by an amount equal to the Accelerated Benefit paid such Insured. Such reduced amount of insurance will be subject to all Policy provisions dealing with changes in the amount of insurance and reductions or termination for age or retirement. The amount of the Accelerated Benefit plus the corresponding Death Benefit will not exceed the amount that would have been paid as the Death

Benefit in the absence of this Rider.

(2) Any amount of insurance that would otherwise be continued under a Waiver of Premium provision will be reduced proportionately, as will the maximum Face Amount available under the Conversion Privilege.

MISSTATEMENT OF AGE OR SEX: The Accelerated Benefit will be adjusted to reflect the amount of benefit that would have been purchased by the actual premium paid at the correct age and sex.

TERMINATION OF AN INDIVIDUAL'S COVERAGE UNDER THIS RIDER: The coverage of any Insured under this Rider will terminate on the first of the following:

(1) the date his coverage under the Policy terminates;

(2) the date of payment of the Accelerated Benefit for his Terminal Illness; or

(3) the date he attains age 75.

ADDITIONAL PROVISIONS: This Rider takes effect on the Effective Date shown. It will terminate on the date the Group Policy terminates. It is subject to all the terms of the Group Policy not inconsistent herewith.

In witness whereof, we have caused this Rider to be signed by our Secretary.

Secretary

ACCELERATED BENEFIT RIDER DISCLOSURE
FOR RIDER LRS-8596-001-0200 IL

The Accelerated Benefit option is an advance payment of life insurance proceeds under our group term life insurance program. This option allows the Insured to access the face amount of his insurance coverage prior to death if he is diagnosed as having less than 24 months to live. There are no restrictions placed on how the proceeds may be used.

ELIGIBILITY: The Insured is eligible to exercise the Accelerated Benefit option if, after having been covered under the Rider for at least thirty (30) days (this thirty (30) day elimination period does not apply with respect to a condition resulting from an accident), he has been diagnosed as having a medical condition which will result in a drastically limited life-span, and his doctor certifies that death will occur within 24 months. We reserve the right to investigate further to verify eligibility.

THE BENEFIT: The Accelerated Benefit Option pays 75% of the Insured's basic term life insurance benefit, to a maximum of $500,000, in a single lump sum or in installment payments mutually agreed to by us and the Insured. The portion of the death benefit which is not accelerated is payable to his beneficiary at his death.

There is no additional premium charge for the Accelerated Benefit Rider. There is no reduction in the premium for the group term life insurance coverage if benefits become payable under this Rider.

If the group Policy and/or the Insured's life insurance benefits under the Group Policy terminate, all of the Insured's rights under the Accelerated Benefit Rider also terminate.

EFFECT OF BENEFIT: Receipt of the Accelerated Benefit may be taxable and could adversely affect the Insured's eligibility for Medicaid or other government benefits or entitlements. It is recommended that the Insured consult his personal tax advisor for clarification of the current tax law with respect to accelerated death benefits.

ILLINOIS
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

DISCLAIMER

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life and Health Insurance Guaranty Association
8420 West Bryn Mawr Avenue
Chicago, Illinois 60631
(773) 714-8050

Illinois Department of Insurance
320 West Washington Street
4th Floor
Springfield, Illinois 62767
(217) 782-4515

(please refer to next page)

SUMMARY OF GENERAL PURPOSES AND CURRENT LIMITATIONS OF COVERAGE

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") (215 ILCS 5/531.01, et seq.). The following contains a brief summary of the Law's coverages, exclusions, and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

A. Coverage:

The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:

(1) life insurance, health insurance, and annuity contracts;
(2) life, health or annuity certificates under direct group policies or contracts;
(3) unallocated annuity contracts; and
(4) contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.

B. Exclusions from Coverage:

(1) The Guaranty Association does not provide coverage for:
  (a) any policy or portion of a policy for which the individual has assumed the risk;
  (b) any policy of reinsurance (unless an assumption certificate was issued);
  (c) interest rate guarantees which exceed certain statutory limitations;
  (d) certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
  (e) any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
  (f) any stop loss insurance.

(2) In addition, persons are not protected by the Guaranty Association if:
  (a) the Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
  (b) their policy was issued by an organization which is not a member insurer of the Association.

C. Limits on Amount of Coverage:

(1) The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Association's liability is limited to the lesser of either:
  (a) the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
  (b) with respect to any one life, regardless of the number of policies, contracts, or certificates:
    (i) in the case of life insurance, $300,000 in death benefits but not more than $100,000 in net cash surrender or withdrawal values;
    (ii) in the case of health insurance, $300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
    (iii) with respect to annuities, $100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and $100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is $5,000,000 in benefits per contract holder, regardless of the number of contracts.
(2) However, in no event is the Guaranty Association liable for more than $300,000 with respect to any one individual.

Claim Procedures and ERISA Statement of Rights

CLAIM PROCEDURES FOR CLAIMS FILED WITH
RELIANCE STANDARD LIFE INSURANCE COMPANY
ON OR AFTER JANUARY 1, 2002

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed form along with any requested information to:

Reliance Standard Life Insurance Company
Claims Department
P.O. Box 8330
Philadelphia, PA 19101-8330

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling 1-800-644-1103.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
If a non-disability claim is wholly or partially denied, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 90 days after our receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

Disability Benefit Claims
In the case of a claim for disability benefits, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 45 days after our receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond our control and that notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
A Claimant shall be provided with written notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review.

Disability Benefit Claims

A claimant shall be provided with written notification of any adverse benefit determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review; and
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of adverse benefit determinations may be submitted in accordance with the following procedures to:

Reliance Standard Life Insurance Company
Quality Review Unit
P.O. Box 8330
Philadelphia, PA 19101-8330

Non-Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;

6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination; and
8. In deciding the appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:

   (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
   (b) who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal; nor the subordinate of any such individual.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims

A claimant shall be provided with written notification of the benefit determination on review. In the case of an adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable).

Disability Benefit Claims

A claimant must be provided with written notification of the determination on review. In the case of adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable);
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and
6. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency" (where applicable).

DEFINITIONS

The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan.

The term "us" or "our" refers to Reliance Standard Life Insurance Company.

The term "relevant" means:

A document, record, or other information shall be considered relevant to a claimant's claim if such document, record or other information:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or
- In the case of a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The term "Reliance Standard Life Insurance Company" means Reliance Standard Life Insurance Company and/or its authorized claim administrators.

ERISA STATEMENT OF RIGHTS

As a participant in the Group Insurance Plan, you may be entitled to certain rights and protections in the event that the Employee Retirement Income Security Act of 1974 (ERISA) applies. ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.