RESOLUTION NO. ____

A RESOLUTION AUTHORIZING EXECUTION OF PLAN AMENDMENTS TO THE VILLAGE OF DOWNERS GROVE GROUP HEALTH PLAN

BE IT RESOLVED by the Village Council of the Village of Downers Grove, DuPage County, Illinois, as follows:

1. That the form and substance of certain Plan Amendments #3, #4 and #5 (the AAmendments@), between the Village of Downers Grove (the AVillage@) and Advocate Health Partners for and on behalf of Advocate Good Samaritan hospital, a hospital operating division of Advocate Health and Hospitals Corporation (hereinafter referred to as "Hospital") and Village of Downers Grove (hereinafter referred to as "Employer"), providing for 2010 policy revisions to the Village's health insurance plan, as set forth in the form of the Amendments submitted to this meeting with the recommendation of the Village Manager, is hereby approved.

2. That the Village Manager and Village Clerk are hereby respectively authorized and directed for and on behalf of the Village to execute, attest, seal and deliver the Amendments, substantially in the form approved in the foregoing paragraph of this Resolution, together with such changes as the Manager shall deem necessary.

3. That the proper officials, agents and employees of the Village are hereby authorized and directed to take such further action as they may deem necessary or appropriate to perform all obligations and commitments of the Village in accordance with the provisions of the Amendments.

4. That all resolutions or parts of resolutions in conflict with the provisions of this Resolution are hereby repealed.

5. That this Resolution shall be in full force and effect from and after its passage as provided by law.

_____
Mayor

Passed:
Attest: _____
Village Clerk

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PLAN AMENDMENT
FOR

VILLAGE OF DOWNERS GROVE
GROUP HEALTH PLAN

GOOD SAMARITAN AND LOW DEDUCTIBLE PLANS
AND
HIGH DEDUCTIBLE PLAN

Amendment No. 3
Effective Date: As Reflected Herein

This Plan is **AMENDED** effective January 1, 2009 as follows:

I. Section – Outpatient Prescription Drug Card Benefit: Benefit Payment for Prescription Drugs – Restate as follows:

Benefit Payment for Prescription Drugs

Benefits for prescription drugs covered under this Outpatient Prescription Drug Card Benefit will not be provided under any other section of this Plan.

Short Term - Acute Drugs

When you obtain drugs from a Participating Prescription Drug Provider, your Copayment for each prescription is:

Generic Drugs	$10
Brand-Name Drugs	$35
Self-Injectable Medications	25% of Covered Charges, limited to a total maximum Copayment of $4,000 person per Calendar Year.

Benefits will be provided for the remaining eligible charge. One prescription means up to a 34-consecutive day supply of a drug.

Long Term - Maintenance Drugs - Mail Order

When you obtain drugs from the Mail Order Prescription Drug Provider, your Copayment for each prescription is:

Generic Drugs	$ 30
Brand-Name Drugs	$105

Benefits will be provided for the remaining eligible charge. Maintenance drug prescription means up to a 90-consecutive day supply of a drug.

II. Section: Medical Expense Covered Charges – Add the following provisions:

1. In compliance with Illinois Public Act 95-422 and Public Act 95-978 (and any subsequent amendments), charges Incurred for the following vaccines that are approved by the U.S. Food and Drug Administration:
   a. A human papillomavirus vaccine (HPV).
   b. A shingles vaccine when ordered by a Physician for Covered Persons age 60 or over.

2. In compliance with Illinois Public Act 95-1005 (and any subsequent amendments), charges Incurred by a Covered Dependent under age 21 for:

   a. The diagnosis of autism spectrum disorder; and,

   b. The following services prescribed by a Physician and rendered by a licensed provider when such treatment is Medically Necessary and result in improved clinical status:

      - Psychiatric care;
      - Psychological care;
      - Habilitative or rehabilitative care (i.e. counseling and treatment programs intended to develop, maintain, and restore the function of an individual);
      - Therapeutic care, including behavioral, speech, occupational, and physical therapies addressing the following areas: self care and feeding; pragmatic, receptive, and expressive language; cognitive functioning; applied behavioral analysis, intervention, and modification; motor planning; and, sensory processing.

   Benefits payable under this provision will be limited to a maximum of $36,000 per person per Calendar Year and will not be subject to the limitations otherwise applicable to the treatment of a Mental Health Illness.

III. Section: Definitions – Revise the following provisions:

Experimental, Investigational/Investigative or Unproved

"Experimental", "Investigational", "Investigative", or "Unproved" shall mean a drug, device, medical Treatment or procedure that meets any one of the following:

1. The drug or device cannot be lawfully used or marketed without approval by the appropriate federal or other governmental agency which has not been granted, such as, but not limited to, the U.S. Federal Drug Administration (FDA). For purposes of this subparagraph, a drug or device being used for an indication or at a dosage that reliable evidence shows is an accepted off-label use will not be considered to be "experimental", "investigative" or "unproved".

   Off-label use of drugs will be allowable under the Plan if it meets the following criteria:

   The use of the drugs is supported by one or more citations in The American Hospital Formulary Service Drug Information, Micromedex DrugPoints, Facts and Comparisons, NCCN, Clinical Pharmacology, the Association of Community Cancer Centers or any CMS supported compendia, providing the use is **not** listed as "not indicated" in any one of the listed compendia.

2. The drug, device, medical Treatment or procedure, or the patient informed-consent document utilized with the drug, device, Treatment or procedure, is subject to an ongoing review by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval.

3. Reliable Evidence shows that the drug, device, medical Treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of Treatment or diagnosis; or

4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical 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 a standard means of Treatment or diagnosis.

"Reliable Evidence" shall mean only consensus findings, opinions or recommendations published in the authoritative medical and scientific literature or peer-reviewed literature; reports of clinical trial committees and other technology assessment bodies; consensus opinions of local and national health care providers in the specialty or subspecialty that would typically manage the sickness or injury for which the drug, device, technology, treatment, supply or procedure is proposed; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical Treatment or procedures; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical Treatment or procedure.

The Plan Administrator will rely on various sources to assist in determining "Experimental, Investigative or Unproved" services. These sources may include, but are not limited to: The DATTA program of the American Medical Association, the Hayes Manual, the National Institute of Health, the U.S. Food and Drug Administration, the National Cancer Institute, Office of Health Technology Assessment and Congressional Office of Technology Assessment.

Medical Necessity or Medically Necessary

"Medical Necessity" or "Medically Necessary" means services or supplies provided by a Hospital, Physician or other covered provider which are not excluded under this Plan, which are provided to treat or diagnose an Illness or Injury, and which are determined by the Plan Administrator to meet the following criteria:

1. It is consistent with the symptoms or diagnosis and treatment of the Illness or Injury;
2. It is not primarily for the convenience of the Covered Person, Physician or other provider;
3. It does not involve unnecessary or repeated tests;
4. It is not of an Experimental, Investigational or educational nature. Drugs and drug treatment in one or more compendia qualifying for Medicare reimbursement will not be considered Experimental or Investigational;
5. It is furnished by a provider with appropriate training and experience, acting within the scope of his license, and it is provided at the most appropriate level of care needed to treat the particular Condition; and,
6. Meets the following definition of standard of care.

Standard of care refers to an acceptable level of patient care provided by a medical practitioner. It considers how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances.

Standard of care is sometimes referred to as "standard therapy" or "best practice" and is generally satisfied by any medicine or treatment that experts agree is consistent with generally accepted standards of medical practice, is appropriate, accepted, and widely used for a certain type of patient, illness, or clinical circumstance. Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

The administration of a non-approved experimental drug, procedure or device, or the participation in a Phase III clinical trial will not invalidate coverage for treatment that is considered an approved standard of care based on peer review.

The Plan Administrator will analyze whether these requirements have been met based upon:

1. Published reports in authoritative medical and scientific literature;
2. Regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA) and CMS;
3. Listings in the following compendia: The American Hospital Formulary Service Drug Information, Micromedex DrugPoints, Facts and Comparisons, NCCN, Clinical Pharmacology, the Association of Community Cancer Centers or any CMS supported compendia; and

4. Other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

This Plan is **AMENDED** effective April 1, 2009 as follows:

Section: Special Enrollment Periods – Add the following:

Special Enrollment Rights – Medicaid or State Child Health Insurance Plan

The Plan will permit Special Enrollment if you or your Dependent(s) are eligible but not enrolled in the following circumstances:

1. Your coverage or your Dependent's coverage under Medicaid or a State Child Health Insurance Plan (i.e. CHIP) has terminated as a result of loss of eligibility and you request coverage under the Plan within 60 days after the termination; or
2. You or your Dependent becomes eligible for a premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and you request coverage under the Plan within 60 days after eligibility is determined.

If you enroll during the 60-day Special Enrollment Period defined above, coverage will become effective on the first day of the month following the date the Plan receives your request for special enrollment.

Accepted for Plan Administrator:

By: _____

Title: _____

Date: _____

PLAN AMENDMENT
FOR

VILLAGE OF DOWNERS GROVE
GROUP HEALTH PLAN

GOOD SAMARITAN AND LOW DEDUCTIBLE PLANS
AND
HIGH DEDUCTIBLE PLAN

Amendment No. 4
Effective Date: September 1, 2009

This Plan is **AMENDED** as follows:

I. Section: Retirees – Restate as follows:

Retirees

Retirees eligible for coverage are:

- Eligible Employees who elect to participate in the Voluntary Separation Program offered by the Employer as of September 1, 2009. Coverage continuation will be provided in keeping with the plan option selected by the employee under such program. The two plan options available are: the Low Deductible Plan or the Retiree Health Plan (Good Samaritan providers will be considered a PPO provider).

  Coverage continuation at the premium rate stipulated under the Voluntary Separation Program will be available for a maximum of two years under the Low Deductible Plan or four years under the Retiree Health Plan. After the applicable two-year or four-year period, coverage continuation coverage will be available only under the Retiree Health Plan and at the normal premium rate.

- Eligible retirees as determined by established Employer policy.
- Pursuant to 215 ILCS 5/367j, Eligible Employees who qualify for continued coverage due to disability or retirement as defined by the Illinois Pension Code. Additional information concerning this continuation is available from your Employer.

All individuals who retire on or after September 1, 2009, will be eligible for coverage only under the Retiree Health Plan.*

**This requirement does not apply to employees who retired prior to September 1, 2009, who will continue to be eligible for the coverage option(s) specified under the Employer policy in place as of the date of their retirement.*

II. Section: Schedule of Medical Benefits – Add the following:

Retiree Health Plan

Retiree Health Plan		
Calendar Year Deductible		
Per Covered Person	$2,500	
Per Family (aggregate)	$5,000	
Coinsurance by Plan		
Unless otherwise noted, the Plan will pay the benefit specified below:		
PPO Provider:	80% after satisfying the Deductible	
Non-PPO Provider:	60% after satisfying the Deductible	
Coinsurance Limit		
The Coinsurance limit includes the Deductible.		
	PPO Providers	**Non-PPO Providers**
Per Covered Person	$4,500	$ 6,500
Per Family (aggregate)	$9,000	$13,000
After your Coinsurance equals the above stated amounts per Calendar Year, the Plan will pay 100% of all charges eligible for the Coinsurance limit for the balance of the Calendar Year.		
If a combination of PPO network providers and non-PPO network providers are used, your combined total Coinsurance Limit will not exceed the amount shown for non-PPO network providers. In other words, the amount of expense you will pay for both PPO network providers and non-PPO network providers will be combined, and the total will not exceed the amount shown for non-PPO network providers during a Calendar Year.		
Note: Coinsurance for Treatment of Mental Health and Substance Abuse, infertility treatment, non-compliance penalties, ineligible charges, charges in excess of Usual and Customary, office visit Copays, drug card Copays and other Copays, do not qualify under the Coinsurance limit provision.		

Retiree Health Plan		
Covered Services	***PPO Providers***	***Non-PPO Providers***
Accident Benefit	100% no Deductible	100% no Deductible
Charges Incurred by a Covered Person within 90 days of an Accident for treatment of Injuries sustained in or resulting from an Accident will be covered at 100% (no Deductible) up to a maximum benefit of $500 per person per Accident. Charges that exceed the maximum benefit will be subject to the Deductible and Coinsurance specified under this Schedule, subject to all Plan provisions.		
Allergy Injections	80% after Deductible	60% after Deductible
Ambulance Services	80% after Deductible	60% after Deductible
Chiropractic Services (other than Diagnostic X-ray and Laboratory) Limited to a maximum benefit of $2,500 per person per Calendar Year.	80% after Deductible	60% after Deductible

Retiree Health Plan		
Covered Services	***PPO Providers***	***Non-PPO Providers***
Diagnostic X-Ray & Lab - Inpatient/Outpatient Limited to a maximum first dollar benefit of $300 per person per Calendar Year.	100% no Deductible up to the maximum benefit. Charges that exceed the maximum will be covered at 80% after the Deductible.	100% no Deductible up to the maximum benefit. Charges that exceed the maximum will be covered at 60% after the Deductible.
Durable Medical Equipment	80% after Deductible	60% after Deductible
Emergency Care (Hospital)	80% after Deductible	60% after Deductible
Home Health Care Limited to a maximum of 120 visits per person per Calendar Year.	100% no Deductible	100% no Deductible
Hospice Care	100% no Deductible	100% no Deductible
Hospital Charges – Inpatient/Outpatient	80% after Deductible	60% after Deductible
Infertility Treatment Limited to a maximum benefit of $15,000 per person while covered under this Plan which includes benefits paid under the Outpatient Prescription Drug Card Benefit.	75% after Deductible; does not apply to the Coinsurance limit	75% after Deductible; does not apply to the Coinsurance limit
Newborns • **Well Newborn** Well Baby Care during the Hospital confinement immediately following birth for Hospital nursery, in-Hospital doctor visits and circumcision. • **Sick Newborn**	100% no Deductible Benefits are provided at the level specified in this Schedule for the type of charge Incurred.	100% no Deductible Benefits are provided at the level specified in this Schedule for the type of charge Incurred.
Organ Transplants Limited to a maximum benefit of $200,000 per person for all transplants while covered under the Plan.	Benefits are provided at the level specified in this Schedule for the type of charge Incurred.	Benefits are provided at the level specified in this Schedule for the type of charge Incurred.
Physician Office Visit – Diagnostic	100% after a $20 Copay for the office visit charge.	60% after Deductible
Physician Services – Other	80% after Deductible	60% after Deductible

Retiree Health Plan		
Covered Services	***PPO Providers***	***Non-PPO Providers***
Pre-Admission Testing Performed on an Outpatient basis within 7 days of a scheduled admission. Benefits are not included in or subject to the $300 benefit maximum for Diagnostic or Routine X-ray and Laboratory services.	100% no Deductible	100% no Deductible
Routine Colonoscopy	80% after Deductible	60% after Deductible
Routine Mammograms as Follows: • One baseline exam between age 35 and age 39; • One annual exam for Covered Persons age 40 or older.	100% no Deductible	100% no Deductible
Routine Physical Exam and X-Ray/ Laboratory – Age 2 and Over Eligible Charges include but are not limited to mammograms in excess of the limits stated above, routine physical exams, related x-ray and lab charges (including pap smears and PSA tests), and immunizations up to a maximum benefit of $500 per person per Calendar Year. Charges in excess of the maximum benefit will not be eligible under the Plan.	100% no Deductible	60% after Deductible
Routine Well Child Care – Up to Age 2 Coverage includes routine physical exam, related x-ray and lab charges, and immunizations.	100% no Deductible	60% after Deductible
Skilled Nursing Facility Limited to a maximum of 120 days per person per Calendar Year.	80% after Deductible	60% after Deductible
Surgery • **Hospital Charges** • **Physician (Surgeon and Anesthesiologist)**	80% after Deductible 80% after Deductible	60% after Deductible 60% after Deductible
Therapy – Occupational, Physical and Speech	80% after Deductible	60% after Deductible
Treatment of Mental Health: • **Outpatient Care** Limited to a maximum allowable amount of $100 per visit.	80% after Deductible with CCM approval (60% after Deductible with-out CCM approval); does not apply to the Coinsurance limit	60% after Deductible (CCM approval not required); does not apply to the Coinsurance limit

Retiree Health Plan		
Covered Services	***PPO Providers***	***Non-PPO Providers***
Treatment of Mental Health (continued): • **Inpatient Care/ Intensive Outpatient Treatment** Limited to a maximum of 20 days per person per Calendar Year. Additional Intensive Outpatient Treatment days may be eligible when CCM authorizes such care based on clinical necessity and appropriateness *and* treatment is provided by Good Samaritan or a PPO Provider: **- Hospital**	80% after Deductible with CCM approval, no approval will result in a $500 penalty; does not apply to the Coinsurance limit	60% after Deductible (CCM approval not required); does not apply to the Coinsurance limit
- Physician	80% after Deductible with CCM approval (60% after Deductible with-out CCM approval; does not apply to the Coinsurance limit	60% after Deductible (CCM approval not needed); does not apply to the Coinsurance limit
Treatment of Substance Abuse: • **Outpatient Care** Limited to a maximum allowable amount of $100 per visit and $1,500 per person per Calendar Year.	80% after Deductible with CCM approval (60% after Deductible with-out CCM approval); does not apply to the Coinsurance limit	60% after Deductible (CCM approval not needed); does not apply to the Coinsurance limit
• **Inpatient Care/ Intensive Outpatient Treatment** Inpatient care is limited to a maximum of 2 confinements while covered under this Plan. Overall benefits for Inpatient Care and/or Intensive Outpatient Treatment are limited to a maximum of $25,000 while covered under this Plan: **- Hospital**	80% after Deductible with CCM approval, no approval will result in a $500 penalty; does not apply to the Coinsurance limit	60% after Deductible (CCM approval not needed); does not apply to the Coinsurance limit

Retiree Health Plan		
Covered Services	***PPO Providers***	***Non-PPO Providers***
Treatment of Substance Abuse Inpatient Care/Intensive Outpatient Treatment (continued): **- Physician**	80% after Deductible with CCM approval (60% after Deductible with-out CCM approval); does not apply to the Coinsurance limit	60% after Deductible (CCM approval not needed); does not apply to the Coinsurance limit
Treatment of Temporomandibular Joint Dysfunction (TMJ): • **Surgery** Limited to a maximum of $5,000 per person while covered under this Plan. • **Non-Surgical Treatment** Limited to a maximum of $1,000 per person while covered under this Plan.	50% after Deductible 50% after Deductible	50% after Deductible 50% after Deductible

Overall Maximum Lifetime Benefit for All Benefits:

$2,000,000 per Covered Person for Medical Benefits and Prescription Drug Benefits paid under all Benefit Plan Options offered by the Plan Sponsor which includes any separate lifetime maximum noted in this Schedule of Medical Benefits. The Plan Sponsor's total payment for all benefits under all Benefit Plan Options will not exceed this overall maximum lifetime benefit, whether or not the Covered Person is continuously covered under the Plan.

Important Notation:

Wherever the word "Lifetime" appears in this Summary Plan Description in reference to benefit maximums and limitations, it is understood to mean **"while covered under this Plan."** Under no circumstances does "Lifetime" mean "during the lifetime of the Covered Person".

Accepted for Plan Administrator:

By: _____

Title: _____

Date: _____

PLAN AMENDMENT
FOR

VILLAGE OF DOWNERS GROVE
GROUP HEALTH PLAN

GOOD SAMARITAN AND LOW DEDUCTIBLE PLANS
AND
HIGH DEDUCTIBLE PLAN

Amendment No. 5
Effective Date: January 1, 2010

This Plan is **AMENDED** as follows:

I. To comply with Illinois Public Act 95-0958 (or as subsequently amended), the Plan is modified as follows:

A. Section: Schedule of Benefits: Age Limitation for Eligible Dependent Children – Restate as follows:

Age Limitation for Eligible Dependent Children

Under 26 years of age; however, a Dependent child who is a military veteran is eligible to age 30. Please refer to the definition of "Dependent" for additional information concerning the eligibility requirements for Dependent children.

Coverage ends at the end of the month in which the limiting age is reached or, if sooner, at the end of the month in which the child otherwise ceases to meet the Plan's eligibility requirements (for example, the child marries or is no longer financially dependent on you).

B. Section: Schedule of Benefits – Add the following provision:

Initial Dependent Child Enrollment Period

A one-time 90-day enrollment period will be provided to enroll your eligible Dependent child(ren) for coverage. This 90-day enrollment period begins on December 1, 2009. Coverage for any Dependent child enrolled during this initial enrollment period will become effective on January 1, 2010, and will be subject to all Plan provisions including the Pre-existing Condition limitation. If an eligible Dependent child is not enrolled during the initial enrollment period, enrollment may be requested during a Special Enrollment Period or during a subsequent Open Election/Enrollment Period.

C. Section: Definitions – Restate the following:

Dependent

"Dependent" means any of the following individuals who are eligible for, and have been enrolled for Dependent Coverage under this Plan:

1. The Participant's legal spouse, of the opposite sex, who is a resident of the same country as the Participant. Such spouse must have met all requirements of a valid marriage contract of the state

in which they were married. This does not include common law marriage or any other such arrangements which may be recognized by the state in which they reside.

2. The Participant's child who meets **all** of the following conditions:
   a. Is a resident of the same country as the Participant.
   b. Is unmarried.
   c. Is a natural child, step-child living with the Participant, legally adopted child, or a child who has been placed under Legal Guardianship of the Participant.
   d. **Is financially dependent upon the Participant.** This requirement is waived if the Participant is required to provide coverage, or is required to pay the cost of medical care due to court order or divorce decree of a child not financially dependent on the Participant.
   e. Is under age 26; or,
   f. Is a military veteran who is under age 30 and meets the following requirements:
      (1) Is a resident of the State of Illinois;
      (2) Served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States including the National Guard; and,
      (3) Has received a release or discharge other than a dishonorable discharge.

      The Dependent must submit proof of active service using a DD Form 214 (Member 4 or 6) form (otherwise known as a "Certificate of Release or Discharge from Active Duty") stating the date on which the Dependent was released from service.

   The age requirement referenced in 2,e. will be waived if the child is mentally or physically handicapped and incapable of self-sustaining employment. The child need not be covered under the Plan on the date the incapacitating handicap occurred. However, such Condition must have begun prior to the child's attainment of age 26 and must be of such severity as to incapacitate the child for an extended period of time. Proof of incapacity acceptable to the Plan Administrator must be furnished upon request and as may be required thereafter.

3. Any children who are in the Participant's custody under an interim court order prior to finalization of adoption will be covered.
4. Any children as required by a Qualified Medical Child Support Order (QMCSO).

Those situations specifically excluded from the definitions of a "Dependent" are:

1. A spouse who is legally separated by a court order from the Participant;
2. A former spouse who is legally divorced from the Participant;
3. Any person on active military duty;
4. Any person covered under this Plan as an individual Participant;
5. Any person who is covered as a Dependent by another Participant.

II. Section: Plan Option Selection – Restate as follows:

Plan Option Selection

There are three plan options offered by the Employer: the "Good Samaritan Plan and Low Deductible Plan", the "High Deductible Plan" and the "VEBA Savings Plan" option.* You will be required to select a plan option when you enroll. The plan option you choose will also apply to your Dependents. Plan option elections are irrevocable and may be changed only during the Open Enrollment Period or, if sooner, during a Special Enrollment Period.

**If you retire from Active Service on or after September 1, 2009 and qualify for coverage continuation following retirement, you (and your Dependents) will be eligible for coverage only under the Retiree Health Plan.*

III. Section: Utilization Management for Treatment of Mental Health and Substance Abuse – Restate as follows:

Creative Care Management (CCM) needs to be contacted at (800) 233-4960 to confirm an Inpatient hospitalization. Those individuals who do not contact CCM prior to an Inpatient hospitalization will be subject to a $500 penalty per confinement. In the case of an Urgent Care need or an emergency, CCM must be contacted within 48 hours or by the end of the next regular work day following the date of the Urgent Care or emergency admission. The term "emergency" means an Accident or Illness which requires immediate treatment on an Inpatient basis.

CCM will utilize the Private Health Care Systems (PHCS) Network. To verify if a provider is in the PHCS network, call (866) 680-7427 or visit the PHCS website at www.phcs.com. Any provider not in the PPO network will be paid at the Non-PPO benefit level shown in the Schedule of Medical Benefits.

Verification of eligibility and benefits is the responsibility of the Covered Person and the provider and must be done by contacting Professional Benefit Administrators (PBA) directly at (630) 655-3755.

IV. Section: Outpatient Prescription Drug Card Benefit:

A. Add the following sentence to the second paragraph of this section:

The Outpatient Prescription Drug Card benefit is provided by the Employer through HealthTrans and will continue to be administered by DrugCard, Inc.

B. Benefit Payment for Prescription Drugs: Restate the following provisions:

Short Term - Acute Drugs

When you obtain drugs from a Participating Prescription Drug Provider, your Copayment for each prescription is:

Generic Drugs	$10.00
Brand-Name Drugs	$45.00
Self-Injectable Medications	25% of Covered Charges

Benefits will be provided for the remaining eligible charge. One prescription means up to a 34-consecutive day supply of a drug.

Long Term - Maintenance Drugs - Mail Order

When you obtain drugs from the Mail Order Prescription Drug Provider, your Copayment for each prescription is:

Generic Drugs	$ 30.00
Brand-Name Drugs	$112.50

Benefits will be provided for the remaining eligible charge. Maintenance drug prescription means up to a 90-consecutive day supply of a drug.

V. Section: Schedule of Medical Benefits: Revise as follows:

A.

Good Samaritan Plan and Low Deductible Plan

Calendar Year Deductible

	Good Samaritan Providers	PPO Providers	Non-PPO Providers
Per Covered Person	$ 500	$ 750	$1,500
Per Family (aggregate)	$1,000	$1,500	$3,000

Coinsurance by Plan

Unless otherwise noted, the Plan will pay the benefit specified below:

Good Samaritan Providers	100% after satisfying the Deductible
PPO Provider:	80% after satisfying the Deductible
Non-PPO Provider:	60% after satisfying the Deductible

Coinsurance Limit

The Coinsurance limit includes the Deductible.

	Good Samaritan Providers	PPO Providers	Non-PPO Providers
Per Covered Person	$ 500	$2,750	$ 5,500
Per Family (aggregate)	$1,000	$5,500	$11,000

After your Coinsurance equals the above stated amounts per Calendar Year, the Plan will pay 100% of all charges eligible for the Coinsurance limit for the balance of the Calendar Year.

If a combination of PPO network providers and non-PPO network providers are used, your combined total Deductible and Coinsurance Limit will not exceed the amount shown for non-PPO network providers. In other words, the amount of expense you will pay for both PPO network providers and non-PPO network providers will be combined, and the total will not exceed the amount shown for non-PPO network providers during a Calendar Year.

Note: Coinsurance for infertility treatment, non-compliance penalties, ineligible charges, charges in excess of Usual and Customary, office visit Copays, drug card Copays and other Copays, do not qualify under the Coinsurance limit provision.

Good Samaritan Plan and Low Deductible Plan			
Covered Services	**Good Samaritan Providers**	**PPO Providers**	**Non-PPO Providers**
Accident Benefit	100% no Deductible	100% no Deductible	100% no Deductible
Charges Incurred by a Covered Person within 90 days of an Accident for treatment of Injuries sustained in or resulting from an Accident will be covered at 100% (no Deductible) up to a maximum benefit of $500 per person per Accident. Charges that exceed the maximum benefit will be subject to the Deductible and Coinsurance specified under this Schedule, subject to all Plan provisions.			
Allergy Injections	80% after Deductible	80% after Deductible	60% after Deductible
Ambulance Services	80% after Deductible	80% after Deductible	60% after Deductible

Good Samaritan Plan and Low Deductible Plan			
Covered Services	**Good Samaritan Providers**	**PPO Providers**	**Non-PPO Providers**
Chiropractic Services (other than Diagnostic X-ray and Laboratory) Limited to a maximum benefit of $2,500 per person per Calendar Year.	80% after Deductible	80% after Deductible	60% after Deductible
Diagnostic X-Ray & Lab - Inpatient/Outpatient Limited to a maximum first dollar benefit of $300 per person per Calendar Year.	100% no Deductible up to the maximum benefit. Charges that exceed the maximum will be covered at 100% after the Deductible.	100% no Deductible up to the maximum benefit. Charges that exceed the maximum will be covered at 80% after the Deductible.	100% no Deductible up to the maximum benefit. Charges that exceed the maximum will be covered at 60% after the Deductible.
Durable Medical Equipment	80% after Deductible	80% after Deductible	60% after Deductible
Emergency Care (Hospital)	100% after Deductible	80% after Deductible	60% after Deductible
Home Health Care Limited to a maximum of 120 visits per person per Calendar Year.	100% no Deductible	100% no Deductible	100% no Deductible
Hospice Care	100% no Deductible	100% no Deductible	100% no Deductible
Hospital Charges – Inpatient/Outpatient	100% after Deductible	80% after Deductible	60% after Deductible
HPV Vaccine	80% no Deductible	80% no Deductible	60% after Deductible
Infertility Treatment Limited to a maximum benefit of $15,000 per person while covered under this Plan which includes benefits paid under the Outpatient Prescription Drug Card Benefit.	75% after Deductible; does not apply to the Coinsurance limit	75% after Deductible; does not apply to the Coinsurance limit	75% after Deductible; does not apply to the Coinsurance limit
Newborns • **Well Newborn** Well Baby Care during the Hospital confinement immediately following birth for Hospital nursery, in-Hospital doctor visits and circumcision.	100% no Deductible	100% no Deductible	100% no Deductible
• **Sick Newborn**	Benefits are provided at the level specified in this Schedule for the type of charge Incurred.		

Good Samaritan Plan and Low Deductible Plan			
Covered Services	**Good Samaritan Providers**	**PPO Providers**	**Non-PPO Providers**
Organ Transplants Limited to a maximum benefit of $200,000 per person for all transplants while covered under the Plan.	Benefits are paid in the same manner as any other Illness, subject to the maximum benefit. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.		
Orthotics (Custom Molded)	80% after Deductible	80% after Deductible	60% after Deductible
Physician Office Visit – Diagnostic	100% after a $20 Copay for the office visit charge.	100% after a $20 Copay for the office visit charge.	60% after Deductible
Physician Services – Other	80% after Deductible	80% after Deductible	60% after Deductible
Pre-Admission Testing Performed on an Outpatient basis within 7 days of a scheduled admission. Benefits are not included in or subject to the $300 benefit maximum for Diagnostic or Routine X-ray and Laboratory services.	100% no Deductible	100% no Deductible	100% no Deductible
Routine Colonoscopy	100% after Deductible	80% after Deductible	60% after Deductible
Routine Mammograms as Follows: • One baseline exam between age 35 and age 39; • One annual exam for Covered Persons age 40 or older.	100% no Deductible	100% no Deductible	100% no Deductible
Routine Physical Exam – Age 2 and Over Limited to a maximum benefit of $100 per person per Calendar Years; charges that exceed the maximum benefit will not be eligible under the Plan.	100% no Deductible	100% no Deductible	100% no Deductible
Routine X-Ray/Laboratory – Age 2 and Over Limited to a maximum benefit of $300 per person per Calendar Year; charges in excess of the maximum benefit are not eligible. Covered Charges include but are not limited to pap smears, immunizations (other than HPV or shingles vaccine), PSA tests and mammograms in excess of limits specified under the routine mammogram benefit.	100% no Deductible	100% no Deductible	100% no Deductible

Good Samaritan Plan and Low Deductible Plan			
Covered Services	**Good Samaritan Providers**	**PPO Providers**	**Non-PPO Providers**
Routine Well Child Care – Up to Age 2 Coverage includes routine physical exam, related x-ray and lab charges, and immunizations.	100% no Deductible	100% no Deductible	60% no Deductible
Shingles Vaccine – Covered Persons Age 60 and over	100% no Deductible	100% no Deductible	100% no Deductible
Skilled Nursing Facility Limited to a maximum of 120 days per person per Calendar Year.	100% after Deductible	80% after Deductible	60% after Deductible
Surgery			
• **Hospital Charges**	100% after Deductible	80% after Deductible	60% after Deductible
• **Physician (Surgeon and Anesthesiologist)**	80% after Deductible	80% after Deductible	60% after Deductible
Therapy – Occupational, Physical and Speech	80% after Deductible	80% after Deductible	60% after Deductible
Treatment of Mental Health Illness/Substance Abuse:	Benefits are paid in the same manner as any other Illness. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit. CCM approval required for Inpatient confinements.		
Treatment of Temporomandibular Joint Dysfunction (TMJ):			
• **Surgery** Limited to a maximum of $5,000 per person while covered under this Plan.	50% after Deductible	50% after Deductible	50% after Deductible
• **Non-Surgical Treatment** Limited to a maximum of $1,000 per person while covered under this Plan.	50% after Deductible	50% after Deductible	50% after Deductible

Overall Maximum Lifetime Benefit for All Benefits:

$2,000,000 per Covered Person for Medical Benefits and Prescription Drug Benefits paid under all Benefit Plan Options offered by the Plan Sponsor which includes any separate lifetime maximum noted in this Schedule of Medical Benefits. The Plan Sponsor's total payment for all benefits under all Benefit Plan Options will not exceed this overall maximum lifetime benefit, whether or not the Covered Person is continuously covered under the Plan.

Important Notation:

Wherever the word "Lifetime" appears in this Summary Plan Description in reference to benefit maximums and limitations, it is understood to mean **"while covered under this Plan."** Under no circumstances does "Lifetime" mean "during the lifetime of the Covered Person".

B.

High Deductible Plan

Calendar Year Deductible

	Good Samaritan Providers	PPO Providers	Non-PPO Providers
Per Covered Person	$ 500	$1,500	$3,000
Per Family (aggregate)	$1,000	$3,000	$6,000

Coinsurance by Plan

Unless otherwise noted, the Plan will pay the benefit specified below:

Good Samaritan Providers	100% after satisfying the Deductible
PPO Provider:	80% after satisfying the Deductible
Non-PPO Provider:	60% after satisfying the Deductible

Coinsurance Limit

The Coinsurance limit includes the Deductible.

	Good Samaritan Providers	PPO Providers	Non-PPO Providers
Per Covered Person	$ 500	$3,500	$ 7,000
Per Family (aggregate)	$1,000	$7,000	$14,000

After your Coinsurance equals the above stated amounts per Calendar Year, the Plan will pay 100% of all charges eligible for the Coinsurance limit for the balance of the Calendar Year.

If a combination of PPO network providers and non-PPO network providers are used, your combined total Deductible and Coinsurance Limit will not exceed the amount shown for non-PPO network providers. In other words, the amount of expense you will pay for both PPO network providers and non-PPO network providers will be combined, and the total will not exceed the amount shown for non-PPO network providers during a Calendar Year.

Note: Coinsurance for infertility treatment, non-compliance penalties, ineligible charges, charges in excess of Usual and Customary, office visit Copays, drug card Copays and other Copays, do not qualify under the Coinsurance limit provision.

High Deductible Plan			
Covered Services	**Good Samaritan Providers**	**PPO Providers**	**Non-PPO Providers**
Accident Benefit	100% no Deductible	100% no Deductible	100% no Deductible
Charges Incurred by a Covered Person within 90 days of an Accident for treatment of Injuries sustained in or resulting from an Accident will be covered at 100% (no Deductible) up to a maximum benefit of $500 per person per Accident. Charges that exceed the maximum benefit will be subject to the Deductible and Coinsurance specified under this Schedule, subject to all Plan provisions.			
Allergy Injections	80% after Deductible	80% after Deductible	60% after Deductible
Ambulance Services	80% after Deductible	80% after Deductible	60% after Deductible

High Deductible Plan			
Covered Services	**Good Samaritan Providers**	**PPO Providers**	**Non-PPO Providers**
Chiropractic Services (other than Diagnostic X-ray and Laboratory) Limited to a maximum benefit of $2,500 per person per Calendar Year.	80% after Deductible	80% after Deductible	60% after Deductible
Diagnostic X-Ray & Lab - Inpatient/Outpatient Limited to a maximum first dollar benefit of $300 per person per Calendar Year.	100% no Deductible up to the maximum benefit. Charges that exceed the maximum will be covered at 100% after the Deductible.	100% no Deductible up to the maximum benefit. Charges that exceed the maximum will be covered at 80% after the Deductible.	100% no Deductible up to the maximum benefit. Charges that exceed the maximum will be covered at 60% after the Deductible.
Durable Medical Equipment	80% after Deductible	80% after Deductible	60% after Deductible
Emergency Care (Hospital)	100% after Deductible	80% after Deductible	60% after Deductible
Home Health Care Limited to a maximum of 120 visits per person per Calendar Year.	100% no Deductible	100% no Deductible	100% no Deductible
Hospice Care	100% no Deductible	100% no Deductible	100% no Deductible
Hospital Charges – Inpatient/Outpatient	100% after Deductible	80% after Deductible	60% after Deductible
HPV Vaccine	80% no Deductible	80% no Deductible	60% after Deductible
Infertility Treatment Limited to a maximum benefit of $15,000 per person while covered under this Plan which includes benefits paid under the Outpatient Prescription Drug Card Benefit.	75% after Deductible; does not apply to the Coinsurance limit	75% after Deductible; does not apply to the Coinsurance limit	75% after Deductible; does not apply to the Coinsurance limit
Newborns • **Well Newborn** Well Baby Care during the Hospital confinement immediately following birth for Hospital nursery, in-Hospital doctor visits and circumcision.	100% no Deductible	100% no Deductible	100% no Deductible
• **Sick Newborn**	Benefits are provided at the level specified in this Schedule for the type of charge Incurred.		

High Deductible Plan			
Covered Services	**Good Samaritan Providers**	**PPO Providers**	**Non-PPO Providers**
Organ Transplants Limited to a maximum benefit of $200,000 per person for all transplants while covered under the Plan.	Benefits are paid in the same manner as any other Illness, subject to the maximum benefit. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.		
Orthotics (Custom Molded)	80% after Deductible	80% after Deductible	60% after Deductible
Physician Office Visit – Diagnostic	100% after a $20 Copay for the office visit charge.	100% after a $20 Copay for the office visit charge.	60% after Deductible
Physician Services – Other	80% after Deductible	80% after Deductible	60% after Deductible
Pre-Admission Testing Performed on an Outpatient basis within 7 days of a scheduled admission. Benefits are not included in or subject to the $300 benefit maximum for Diagnostic or Routine X-ray and Laboratory services.	100% no Deductible	100% no Deductible	100% no Deductible
Routine Colonoscopy	100% after Deductible	80% after Deductible	60% after Deductible
Routine Mammograms as Follows: • One baseline exam between age 35 and age 39; • One annual exam for Covered Persons age 40 or older.	100% no Deductible	100% no Deductible	100% no Deductible
Routine Physical Exam – Age 2 and Over Limited to a maximum benefit of $100 per person per Calendar Years; charges that exceed the maximum benefit will not be eligible under the Plan.	100% no Deductible	100% no Deductible	100% no Deductible
Routine X-Ray/Laboratory – Age 2 and Over Limited to a maximum benefit of $300 per person per Calendar Year; charges in excess of the maximum benefit are not eligible. Covered Charges include but are not limited to pap smears, immunizations (other than HPV or shingles vaccine), PSA tests and mammograms in excess of limits specified under the routine mammogram benefit.	100% no Deductible	100% no Deductible	100% no Deductible

High Deductible Plan			
Covered Services	**Good Samaritan Providers**	**PPO Providers**	**Non-PPO Providers**
Routine Well Child Care – Up to Age 2 Coverage includes routine physical exam, related x-ray and lab charges, and immunizations.	100% no Deductible	100% no Deductible	60% no Deductible
Shingles Vaccine – Covered Persons Age 60 and over	100% no Deductible	100% no Deductible	100% no Deductible
Skilled Nursing Facility Limited to a maximum of 120 days per person per Calendar Year.	100% after Deductible	80% after Deductible	60% after Deductible
Surgery			
• **Hospital Charges**	100% after Deductible	80% after Deductible	60% after Deductible
• **Physician (Surgeon and Anesthesiologist)**	80% after Deductible	80% after Deductible	60% after Deductible
Therapy – Occupational, Physical and Speech	80% after Deductible	80% after Deductible	60% after Deductible
Treatment of Mental Health Illness/Substance Abuse:	Benefits are paid in the same manner as any other Illness. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit. CCM approval required for Inpatient confinements.		
Treatment of Temporomandibular Joint Dysfunction (TMJ):			
• **Surgery** Limited to a maximum of $5,000 per person while covered under this Plan.	50% after Deductible	50% after Deductible	50% after Deductible
• **Non-Surgical Treatment** Limited to a maximum of $1,000 per person while covered under this Plan.	50% after Deductible	50% after Deductible	50% after Deductible

Overall Maximum Lifetime Benefit for All Benefits:

$2,000,000 per Covered Person for Medical Benefits and Prescription Drug Benefits paid under all Benefit Plan Options offered by the Plan Sponsor which includes any separate lifetime maximum noted in this Schedule of Medical Benefits. The Plan Sponsor's total payment for all benefits under all Benefit Plan Options will not exceed this overall maximum lifetime benefit, whether or not the Covered Person is continuously covered under the Plan.

Important Notation:

Wherever the word "Lifetime" appears in this Summary Plan Description in reference to benefit maximums and limitations, it is understood to mean **"while covered under this Plan."** Under no circumstances does "Lifetime" mean "during the lifetime of the Covered Person".

C. Retiree Health Plan: Restate the following provisions thereby removing any maximum benefit limitation referenced to such treatment in this Plan; Coinsurance for Covered Expenses will apply to the Coinsurance Limit:

Covered Services	PPO Providers	Non-PPO Providers
Treatment of Mental Health Illness	Benefits are paid in the same manner as any other illness; please refer to the specific service or supply outlined in this Schedule for the applicable benefit.	
Treatment of Substance Abuse	Benefits are paid in the same manner as any other illness; please refer to the specific service or supply outlined in this Schedule for the applicable benefit.	

VI. Section: Schedule of Medical Benefits: Add the following plan option:

VEBA Savings Plan

Calendar Year Deductible

Per Covered Person	$2,500
Per Family (aggregate)	$5,000

A VEBA has been established for the enrolling member through an ING Annuity in his or her name. If you enroll for Single coverage it will be a monthly deposit of $83.33 ($1,000 annual) and for a Family it will be a monthly deposit of $166.66 ($2,000 annual). Monies that have accumulated can be accessed to offset qualified medical expenses after all Section 125/flexible spending dollars have been exhausted.

Coinsurance by Plan

Unless otherwise noted, the Plan will pay the benefit specified below:

PPO Provider:	80% after satisfying the Deductible
Non-PPO Provider:	60% after satisfying the Deductible

Coinsurance Limit

The Coinsurance limit includes the Deductible.

	PPO Providers	Non-PPO Providers
Per Covered Person	$4,500	$ 6,500
Per Family (aggregate)	$9,000	$13,000

After your Coinsurance equals the above stated amounts per Calendar Year, the Plan will pay 100% of all charges eligible for the Coinsurance limit for the balance of the Calendar Year.

If a combination of PPO network providers and non-PPO network providers are used, your combined total Coinsurance Limit will not exceed the amount shown for non-PPO network providers. In other words, the amount of expense you will pay for both PPO network providers and non-PPO network providers will be combined, and the total will not exceed the amount shown for non-PPO network providers during a Calendar Year.

Note: Coinsurance for infertility treatment, non-compliance penalties, ineligible charges, charges in excess of Usual and Customary, office visit Copays, drug card Copays and other Copays, do not qualify under the Coinsurance limit provision.

VEBA Savings Plan		
Covered Services	***PPO Providers***	***Non-PPO Providers***
Accident Benefit	100% no Deductible	100% no Deductible
Charges Incurred by a Covered Person within 90 days of an Accident for treatment of Injuries sustained in or resulting from an Accident will be covered at 100% (no Deductible) up to a maximum benefit of $500 per person per Accident. Charges that exceed the maximum benefit will be subject to the Deductible and Coinsurance specified under this Schedule, subject to all Plan provisions.		
Allergy Injections	80% after Deductible	60% after Deductible
Ambulance Services	80% after Deductible	60% after Deductible
Chiropractic Services (other than Diagnostic X-ray and Laboratory) Limited to a maximum benefit of $2,500 per person per Calendar Year.	80% after Deductible	60% after Deductible
Diagnostic X-Ray & Lab - Inpatient/Outpatient Limited to a maximum first dollar benefit of $300 per person per Calendar Year.	100% no Deductible up to the maximum benefit. Charges that exceed the maximum will be covered at 80% after the Deductible.	100% no Deductible up to the maximum benefit. Charges that exceed the maximum will be covered at 60% after the Deductible.
Durable Medical Equipment	80% after Deductible	60% after Deductible
Emergency Care (Hospital)	80% after Deductible	60% after Deductible
Home Health Care Limited to a maximum of 120 visits per person per Calendar Year.	100% no Deductible	100% no Deductible
Hospice Care	100% no Deductible	100% no Deductible
Hospital Charges – Inpatient/Outpatient	80% after Deductible	60% after Deductible
HPV Vaccine	80% no Deductible	60% after Deductible
Infertility Treatment Limited to a maximum benefit of $15,000 per person while covered under this Plan which includes benefits paid under the Outpatient Prescription Drug Card Benefit.	75% after Deductible; does not apply to the Coinsurance limit	75% after Deductible; does not apply to the Coinsurance limit

VEBA Savings Plan		
Covered Services	***PPO Providers***	***Non-PPO Providers***
Newborns: • **Well Newborn** Well Baby Care during the Hospital confinement immediately following birth for Hospital nursery, in-Hospital doctor visits and circumcision.	100% no Deductible	100% no Deductible
• **Sick Newborn**	Benefits are provided at the level specified in this Schedule for the type of charge Incurred.	
Organ Transplants Limited to a maximum benefit of $200,000 per person for all transplants while covered under the Plan.	Benefits are paid in the same manner as any other Illness, subject to the maximum benefit. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.	
Orthotics (Custom Molded)	80% after Deductible	60% after Deductible
Physician Office Visit – Diagnostic	100% after a $20 Copay for the office visit charge.	60% after Deductible
Physician Services – Other	80% after Deductible	60% after Deductible
Pre-Admission Testing Performed on an Outpatient basis within 7 days of a scheduled admission. Benefits are not included in or subject to the $300 benefit maximum for Diagnostic or Routine X-ray and Laboratory services.	100% no Deductible	100% no Deductible
Routine Colonoscopy	80% after Deductible	60% after Deductible
Routine Mammograms as Follows: • One baseline exam between age 35 and age 39; • One annual exam for Covered Persons age 40 or older.	100% no Deductible	100% no Deductible
Routine Physical Exam and X-Ray/ Laboratory – Age 2 and Over Limited to a maximum benefit of $500 per person per Calendar Year; charges in excess of the maximum benefit are not eligible. Covered Charges include but are not limited to routine physical exams, related x-ray and lab charges (including pap smears and PSA tests), immunizations (other than HPV or shingles vaccine) and mammograms in excess of the limits specified under the routine mammogram benefit.	100% no Deductible	60% after Deductible

VEBA Savings Plan		
Covered Services	***PPO Providers***	***Non-PPO Providers***
Routine Well Child Care – Up to Age 2 Coverage includes routine physical exam, related x-ray and lab charges, and immunizations.	100% no Deductible	60% after Deductible
Shingles Vaccine – Covered Persons Age 60 and over	100% no Deductible	100% no Deductible
Skilled Nursing Facility Limited to a maximum of 120 days per person per Calendar Year.	80% after Deductible	60% after Deductible
Surgery • **Hospital Charges**	80% after Deductible	60% after Deductible
• **Physician (Surgeon and Anesthesiologist)**	80% after Deductible	60% after Deductible
Therapy – Occupational, Physical and Speech	80% after Deductible	60% after Deductible
Treatment of Mental Health Illness/ Substance Abuse:	Benefits are paid in the same manner as any other Illness. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit. CCM approval required for Inpatient confinements.	
Treatment of Temporomandibular Joint Dysfunction (TMJ): • **Surgery** Limited to a maximum of $5,000 per person while covered under this Plan.	50% after Deductible	50% after Deductible
• **Non-Surgical Treatment** Limited to a maximum of $1,000 per person while covered under this Plan.	50% after Deductible	50% after Deductible
Overall Maximum Lifetime Benefit for All Benefits: $2,000,000 per Covered Person for Medical Benefits and Prescription Drug Benefits paid under all Benefit Plan Options offered by the Plan Sponsor which includes any separate lifetime maximum noted in this Schedule of Medical Benefits. The Plan Sponsor's total payment for all benefits under all Benefit Plan Options will not exceed this overall maximum lifetime benefit, whether or not the Covered Person is continuously covered under the Plan. **Important Notation:** Wherever the word "Lifetime" appears in this Summary Plan Description in reference to benefit maximums and limitations, it is understood to mean **"while covered under this Plan."** Under no circumstances does "Lifetime" mean "during the lifetime of the Covered Person".		

VII. Eliminate the section "Exception to the Schedule of Medical Benefits for Out-of-Area Participants".

VIII. To comply with the Health Breach Notification Rule, the Plan is modified as follows:

A. Section: Definitions – Add the following:

Health Breach Notification Rule

"Health Breach Notification Rule" means 16 CFR Part 318.

B. Section: Privacy Standards – Add the following under item 2 "Disclosure of Protected Health Information ('PHI') to the Plan Sponsor for Plan Administration Purposes":

(In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:)

- Notify participants of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18).
- Notify the Federal Trade Commission of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18).

C. Section: Security Practices – Add the following under "Disclosure of Electronic Protected Health Information ('Electronic PHI') to the Plan Sponsor for Plan Administration Functions":

(To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:)

- Notify participants of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18); and
- Notify the Federal Trade Commission of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18).

IX. Section: General Provisions – Add the following:

GINA

"GINA" means the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of Genetic Information.

The term "Genetic Information" means, with respect to any individual, information about:

- Such individual's genetic tests;
- The genetic tests of family members of such individual; and
- The manifestation of a disease or disorder in family members of such individual.

The term Genetic Information includes participating in clinical research involving genetic services.

Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes.

This Plan will not discriminate in any manner with its participants on the basis of such Genetic Information.

Accepted for Plan Administrator:

By: _____

Title: _____

Date: _____