DENTAL

PLAN DOCUMENT AND

SUMMARY PLAN DESCRIPTION

FOR

THE CITY OF LAKE FOREST

EFFECTIVE DATE OF THIS DENTAL PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION:

January 1, 2018

TABLE OF CONTENTS

Page

INTRODUCTION **1**

DENTAL EXPENSE BENEFITS **2**

Schedule of Dental Benefits 2
Covered Dental Expenses 2
Preventative Services 2
Restorative Services 3
Major Services 3
Orthodontic Services 4
Benefits After Termination 5

GENERAL PLAN EXCLUSIONS AND LIMITATIONS **6**

ELIGIBILITY FOR COVERAGE **8**

General Eligibility Provisions 8
Eligible Employees 8

COORDINATION OF BENEFITS PROVISION **16**

PRIVACY STANDARDS **19**

SECURITY PRACTICES **21**

CLAIM PROCEDURES **22**

COBRA CONTINUATION COVERAGE **30**

DEFINITIONS **35**

GENERAL PLAN INFORMATION **41**

GENERAL PROVISIONS **43**

INTRODUCTION

The City of Lake (herein referred to as "the City") has established the Plan for your benefit, on the terms and conditions described in this Dental Plan Document and Summary Plan Description.

This document is both the Plan Document and the "Summary Plan Description" or "SPD". It has been written for your use and understanding of the broad range of benefits available to you and your Dependents under this Plan. This document is effective as of 12:00 a.m. on January 1, 2018, and is intended to replace all previously distributed materials. Any word or phrase that is capitalized in this document has a special meaning and is defined for you in the "Definitions" section or within the document.

This Plan is a self-funded plan with a Claims Administrator. The Plan Administrator is responsible for all claim decisions. The responsibility to process claims in accordance with the Plan Document and Summary Plan Description may be delegated to the Claims Administrator; however, the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

The benefits of this Plan are only a part of the comprehensive employee benefits program provided for you, and are offered as tangible recognition of your contribution to the City's success.

This Summary Plan Description is intended to give you, our employee, a general understanding of your benefits in MOST situations; particularly the areas of most interest and concern to you. In order to provide you and your family with an explanation of our benefits plan that is both readable and comprehensive, this booklet is condensed, and not every aspect of our benefits are covered here. If you do not understand the language used in this booklet, contact your Human Resources Department for assistance.

During our business hours, you may ask for more specific information on coverage, exclusions, and limitations or ask questions concerning any other area of our benefit plan. We do ask that you please read this booklet thoroughly before bringing your questions in; they may be explained to your satisfaction in this booklet.

Verification of Benefits

A claim cannot be guaranteed until all necessary information is received and reviewed. Such information includes but is not limited to the exact treatment plan and codes, the dates of service, information necessary to confirm appropriate treatment patterns, and eligibility. We need to assure that the treatment is covered and not excluded or limited in some way.

Any verification of benefits given to a provider, Plan Participant or other party, in writing or orally, in person or by telephone, **is not a guarantee of payment under the Plan**.

Claims Incurred upon this written or oral advice may not be payable and, if determined to be not payable under the Plan, will become your responsibility.

DENTAL EXPENSE BENEFITS

Schedule of Dental Benefits

Preventative Benefits	
Coinsurance by Plan	100% no Deductible
Maximum Benefit	None
Restorative and Major Services	
Deductible:	
Covered Person per Calendar Year	$50
Family per Calendar Year (aggregate)	$150
Coinsurance by Plan After Deductible:	
Restorative Services	80%
Major Services	60%
Calendar Year Maximum:	$1,500
Orthodontic Benefits for Covered Dependent Children	
Coinsurance by Plan	50% no Deductible
Lifetime Maximum	$1,700
Orthodontic expenses are eligible for a covered Dependent child until the end of the month in which the child attains age 19.	

Covered Dental Expenses

The term “Covered Dental Expenses” refers to the items of dental expenses for which dental benefits may be payable. Covered Dental Expenses are charges for the following services and supplies, which are certified by the attending Dentist or Physician to be reasonably necessary for the treatment of a dental Condition, to the extent that the charges do not exceed the usual charge of the Dentist or Physician and the Usual and Customary charges generally made in the same locality under similar conditions. A service or supply will be considered “reasonably necessary” if it is: (1) appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the dental condition, Injury or Illness; (2) provided for the diagnosis or direct care and treatment of the dental condition, Injury or Illness; (3) within standards of good dental practice within the organized dental community; (4) not primarily for the convenience of the Covered Person, the Covered Person’s Dentist or another provider; and (5) the most appropriate supply or level of service which can safely be provided.

A “Dentist” is an individual holding a D.D.S. or D.M.D. degree, who is licensed to practice dentistry in the jurisdiction where such services are provided.

A charge is considered to have been Incurred as of the date on which the service or supply for which the charge is made is rendered or obtained.

Preventative Services

1. Routine oral examinations and prophylaxis (cleaning and polishing of teeth), but not more than twice during any Calendar Year.

2. Topical application of fluoride for Dependent children under age 19, but not more than twice during any Calendar Year.

3. Space maintainers that replace prematurely lost teeth for Dependent children under age 19.

4. Emergency oral exams and palliative treatment of dental pain.

5. Dental X-rays, including full mouth X-rays, but not more than once in any period of thirty-six consecutive months; supplementary bitewing X-rays, but not more than twice during any Calendar Year and other dental X-rays required.

6. Periodontal cleaning, but not more than twice during any Calendar Year.

Restorative Services

1. Extractions.

2. Oral Surgery.

3. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or fractured teeth.

4. General anesthesia when Medically Necessary and administered in connection with oral or dental Surgery.

5. Non-surgical treatment of periodontal or other diseases of the tissues of the mouth.

6. Endodontic treatment, including root canal therapy.

7. Injection of antibiotic drugs by the attending Dentist or Physician.

8. Repair or recementing of crowns, inlays, onlays, bridgework or dentures. Relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of thirty-six consecutive months.

9. Sealants for first and second molars for Dependent children under age 16.

10. Non-routine oral examinations, if the examination is made in connection with dental disease, defect or Injury or suspected dental disease, defect or Injury.

11. Home Visits – visits by a Dentist to your home when medically required to render a covered dental service.

12. Analgesia, including nitrous oxide gas.

13. Custom occlusal guards.

Major Services

1. Initial installation of fixed or removable bridgework (including inlays and crowns as abutments) to replace extracted natural teeth.

2. Initial installation of partial or full removable dentures (including any adjustments during the six-month period following installation) replacing extracted natural teeth.

3. Replacement of an existing partial or full removable denture or bridgework by a new denture or bridgework, or the addition of teeth to an existing partial removable denture or bridgework, but only if:

    a. The replacement or addition of teeth is required to replace one or more extracted teeth;

    b. 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; or

c. The existing denture is an immediate temporary denture and replacement by a permanent denture takes place within twelve months from the date of initial installation of the immediate temporary denture (unless otherwise required by applicable law).

The denture replacement benefits are payable only after you have been covered for one year. If, however, the initial placement of an opposing complete denture requires the replacement of the existing complete denture, benefits will be payable for the replacement of that denture.

4. Inlays, onlays, gold fillings or crown restorations to restore diseased or fractured teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored to proper function with an amalgam, silicate, acrylic, synthetic porcelain or composite restoration.

5. Surgical periodontics.

6. Dental implants.

Orthodontic Services

Orthodontic expenses are eligible for covered Dependent children until the end of the month in which the child attains age 19.

Covered Expenses include orthodontic diagnostic procedures and treatment consisting of appliance therapy, provided treatment is rendered, while coverage is in effect. The Dentist must submit a complete treatment plan for approval by the Claims Administrator prior to the start of treatment; including the proposed charges, suggested correction procedure, and approximate time period for the entire Orthodontic Treatment.

When eligible charges for orthodontic services have been prepaid those charges will be considered in their entirety and paid to the maximum benefit.

Diagnostic benefits, including examination, study models, x-rays and all other diagnostic aids, will be provided only once in any 5 year period, beginning with the date of the first visit to the Dentist.

Benefits for active orthodontic treatment are limited to 36 consecutive months of treatment and benefits for retention treatment are limited to 18 consecutive months. If you are receiving treatment when your coverage begins, these time periods will be reduced by the number of months that you have been receiving treatment prior to your coverage beginning.

Deductible Amount

The “Deductible Amount” is the dollar amount of Covered Dental Expenses for which you are responsible. A Deductible will be applied to the Covered Dental Expenses Incurred by each person covered under the Plan once during each Calendar Year as shown in the Schedule of Dental Benefits.

Family Limit - Normally, the Deductible applies separately to each member of the Family. However, after you have satisfied the Family Deductible amount shown in the Schedule of Dental Benefits during any Calendar Year, Covered Dental Expenses Incurred by any other members of your Family during the remainder of the Calendar Year will not be subject to the Deductible amounts.

Pre-determination of Benefits

If a course of treatment can reasonably be expected to involve Covered Dental Expenses of $300 or more, a pre-determination or treatment plan should be filed with the Claims Administrator prior to beginning the course of treatment.

You and your Dentist will be notified of the benefits payable based upon the course of treatment. In determining the amount of benefits payable, consideration will be given to alternate procedures, services or course of treatment that may be performed for the dental Conditions concerned in order to accomplish the desired results based on accepted standards of dental practice.

If a pre-determination or treatment plan is not submitted in advance, the Plan Administrator reserves the right, at the time claim is filed, to make a determination of benefits, taking into account alternate procedures, services or course of treatment, based on accepted standards of dental practice.

Benefits Payable

When you or a Dependent incur Covered Dental Expenses in excess of the Deductible amount for dental care while covered under the Plan, you will become entitled to benefits for Covered Dental Expenses shown in the Schedule of Dental Benefits.

In no event will benefits payable on any Covered Person exceed the maximum benefit amount shown in the Schedule of Dental Benefits.

Maximum Benefit

The amount of the maximum benefit is shown in the Schedule of Dental Benefits. It applies separately to Covered Dental Expenses Incurred by you or your covered Dependents.

Benefits After Termination

If coverage for you or your Dependent terminates for any reason, no benefits are payable for services rendered beyond the date of termination. There will be no extension of benefits for a treatment plan initiated but not completed, including, but not limited to, root canal therapy, crowns, bridges, inlay/onlays, full/partial dentures and orthodontia treatment.

For services to be considered Eligible Expenses, the work must be started and completed prior to or on the date of termination.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses Incurred by all Covered Persons:

1. Services other than those specifically shown as “Covered Dental Expenses”.

2. Charges for treatment by other than a Dentist except for the taking of x-rays, cleaning of teeth and topical application of fluoride which may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by the Dentist.

3. Treatment of TMJ (Temporomandibular Joint Dysfunction).

4. Charges for veneers or similar properties of crowns and pontics for Cosmetic purposes.

5. Charges for replacement made within five years after the last placement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge. This exclusion is waived if replacement is needed because the appliance, crown, inlay, onlay or bridge, while in the oral cavity, is damaged beyond repair due to injury sustained by the Covered Person or following oral surgery in which one or more teeth are removed.

6. Charges for a duplicate prosthetic device or appliance or for the replacement of a lost, missing, or stolen prosthetic device or appliance.

7. Charges for services or supplies, which according to accepted standards of dental practice, are not necessary or which are not recommended or approved by the attending Dentist; or are Experimental in nature.

8. Charges for oral hygiene, dietary instruction or plaque control program.

9. Charges for services or supplies that are Cosmetic in nature or directed toward a Cosmetic end, including charges for personalization or characterization of dentures.

10. Charges for periodontal splinting.

11. Charges for services or supplies that in the absence of this coverage, you would not be required to pay.

12. Charges for appliances, restorations and procedures to alter vertical dimension or restore occlusion.

13. Charges for any dental services if benefits or services for all or any part of the expenses are provided under the City’s group medical Plan.

14. Charges for replacement or repair of an orthodontic appliance.

15. Charges for services received by any Covered Person which are performed by a Close Relative of the Employee or of the Employee’s spouse.

16. Charges for prescription drugs.

17. Charges for equipment sterilization.

18. Services or supplies that are not specifically mentioned in this Plan.

19. Charges Incurred prior to the effective date of coverage under the Plan, or after coverage is terminated, unless otherwise stated.

20. Charges Incurred as a result of war or any act of war, whether declared or undeclared, when the Covered Person is an active member of the armed forces of any country or caused during service by a Covered Person in the armed forces of any country. Excluded charges also include treatment of an Illness or Injury sustained due to a Covered Person’s participation in any act of aggression or any terrorist activity.

21. a. Charges arising out of or in the course of any occupation for wage or profit that a Covered Person has with another employer. Another employer includes being self-employed when workers' compensation coverage is available, regardless of whether such coverage is actually in effect. However, self-employed is not intended to include minors with jobs such as a paper route.

    b. Charges for which benefits are available under any workers' compensation or occupational disease law, or any such similar law which applies to any company the Covered Person works for, whether or not such coverage is actually in effect.

    c. Charges for which benefits are available under any workers' compensation coverage provided by the City for their employees. However, if benefits are denied under such coverage, expenses may be eligible under the Plan.

22. Charges Incurred while confined in a hospital owned or operated by the United States Government or any agency thereof; or charges for service, treatments or supplies furnished by the United States Government or any agency thereof; unless the law requires the Plan to pay.

23. Charges resulting from or occurring during the commission of a Felonious Act (as defined) or aggravated assault by the Covered Person; or while the Covered Person is engaged in an illegal occupation.

24. Charges Incurred in connection with services and supplies which are: (1) not reasonably necessary for the treatment of dental condition; or (2) not recommended and approved by a Dentist or Physician.

25. Charges which exceed the Usual and Customary allowance as determined by any nationally recognized database which the Claims Administrator utilizes.

26. Charges for failure to keep a scheduled visit, charges for completion of a claim form, or late payment fees assessed by the Dentist or Physician or preparation of report(s) to other Dentists or Physicians.

27. Charges Incurred as a result of a motor vehicle accident while the Covered Person was insured or eligible for health benefits or benefits under a valid "No-Fault" automobile policy, or medical pay benefit, but only to the extent of coverage under the "No-Fault" automobile policy or medical pay benefit, unless required by law.

28. Charges Incurred for treatment of an Injury sustained while a Covered Person was incarcerated, or in the custody of any Federal, State or Local authority.

ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan will be in accordance with the eligibility, effective date and termination provisions of this Summary Plan Description.

Any change in the coverage available to you or your Dependents due to a change in your classification will become effective automatically on the classification change date.

If provided under City policy, your coverage will be continued during an approved leave of absence, including disability or temporary layoff. However, in no event will this coverage be continued for longer than the duration specified under such personnel policies of the City.

Regardless of the established leave policies mentioned above, the Plan will at all times comply with the Family and Medical Leave Act of 1993 ("FMLA"). During any leave taken under FMLA, your coverage will be maintained under this Plan on the same conditions as coverage would have been provided if you had been continuously employed during the entire leave period.

General Eligibility Provisions

Eligible Employees

Employees eligible for Plan coverage (hereafter referred to as "Eligible Employees") are all full-time employees who work a fully scheduled work week or those employees who have been determined to be eligible by City policy. You must actually begin work for the City in order to be eligible. If you are unable to begin work as scheduled, you will not be considered an Eligible Employee until the date you start work.

Note: This Plan is intended to comply with all federal, state or local laws, rules, regulations or codes, or any established City policy that has any valid bearing on this Plan, whether or not the Plan has been specifically amended or modified. This includes but is not limited to coverage continuation requirements contained in any state insurance code, including the Illinois Insurance Code for firemen, police officers and municipal employees participating in IMRF, and their surviving covered Dependents.

Retirees

Persons eligible for coverage continuation are as determined by City policy.

Eligible Dependents

If you are an Eligible Employee you may elect to cover your eligible Dependents. An eligible "Dependent" is defined to mean:

1. Your legal spouse, as evidenced by a valid marriage certificate, who is a resident of the same country as you. Such spouse must have met all requirements of a valid marriage contract of the state in which you were married. This does not include common law marriage or any other such arrangements which may be recognized by the state in which you reside.
2. Your partner with whom you have entered into a legal civil union and who is a resident of the same country as you. Such civil union must meet all the requirements of a valid civil union in the State of Illinois or the state in which the civil union was established. A copy of your completed civil union registration will be required at enrollment.

   A partner in a legal civil union is entitled to all benefits provided under this Plan to a married spouse including COBRA. As such, a civil union partner will be a Qualified Beneficiary entitled to independent COBRA election rights and termination or dissolution of a partnership will be considered a Qualifying Event for the partner and any enrolled Dependent children.

   Wherever the term "spouse" is used in this document, an eligible civil union partner is also meant to be included.

   The value of any benefits provided by this Plan for your partner may be considered "imputed" income for federal and state income and payroll tax purposes.

Eligibility for coverage for your civil union partner will end on the date the civil union is legally dissolved.

3. Your child, or a child of your spouse or civil union partner, who meets **all** of the following conditions:

   a. Is a natural child, step-child, legally adopted child, or a child who has been placed under your Legal Guardianship or your spouse/civil union partner's Legal Guardianship; and,

   b. Is less than age 26; or,

   c. Is a Veteran Adult Child. A Veteran Adult Child is an unmarried child who is at least age 26 but under age 30 and meets all of the following requirements:

      (1) Is a resident of the State of Illinois;

      (2) Has 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.

      A Veteran Adult Child must submit proof of active service using a DD214 (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.

   A Dependent child will continue to be eligible beyond age 26 if the child is mentally or physically handicapped and incapable of self-sustaining employment, unmarried and financially dependent upon you for support and maintenance. 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 submitted upon enrollment or, if later, within 60 days after the date on which the Dependent no longer will be eligible because of age, and at reasonable intervals thereafter.

4. Any child who is placed with you under an interim court order prior to finalization of adoption.

5. Any children as required by a Qualified Medical Child Support Order (QMCSO).

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

1. A spouse from whom you are legally separated by a court order;
2. A former spouse from whom you are legally divorced;
3. Any person on active military duty, unless otherwise required by law;
4. Any person covered under this Plan as an Eligible Employee;
5. Any person who is covered as a Dependent by another employee;
6. A Dependent child's spouse or child (unless a grandchild is placed under your Legal Guardianship or your spouse/civil union partner's Legal Guardianship).

Age Limitation for Eligible Dependent Children

A Dependent child is eligible until the end of the month in which he or she attains age 26 except as otherwise specified for a Veteran Adult Child or a handicapped child in the section "Eligible Dependents".

Veteran Adult Child Coverage

Public Act 95-0958 provides for the extension of health, dental and vision coverage for a Veteran Adult Child. Coverage for a Veteran Adult Child will end prior to attainment of age 30 if the child ceases to be an eligible Dependent as defined in this Plan (refer to the section "Eligible Dependents" for additional information).

Dependent children of a Veteran Adult Child are not eligible for coverage unless you have legally adopted the children or are their legal guardian. Court documentation is required to prove the guardianship or adoption.

Your coverage contribution for a Veteran Adult Child will vary from the contribution you make for other eligible Dependents. Therefore, you must contact the Human Resources Department when your child changes to a Veteran Adult Child status.

Initial Eligibility Date

Your initial eligibility date for Plan coverage is the first day of the month following employment as an Eligible Employee. If your date of employment is on the first day of the month, coverage is effective on that day.

Written application for coverage, as required by the Plan, must be made within 30 days of your initial eligibility date.

Annual Enrollment Period

The City will designate an Annual Enrollment Period. An enrollment or change in coverage made during the Annual Enrollment Period will become effective on January 1, provided such request is made by written application as required by the Plan.

Enrollment Rules

Coverage must be requested by written application (and in the manner required by the Plan) within 30 days of your initial eligibility date.

If you do not have eligible Dependents on the date your coverage begins, you must file your written application for Dependent Coverage within 30 days of the date you acquire your Dependent through marriage, birth, adoption, court order or decree. Once you are enrolled for Dependent Coverage, each newly acquired Dependent must also be enrolled within 30 days of the date your spouse or child becomes eligible. However, this enrollment requirement will not apply to a newborn if full Family coverage is in effect prior to the date of a newborn's birth.

If you are declining enrollment for yourself or your Dependents (including your spouse), you may in the future be able to enroll yourself or your Dependents in this Plan under the Special Enrollment Period rules defined in the following section or during the Annual Enrollment Period.

Special Enrollment Periods

This Plan provides Special Enrollment Periods that allow you and/or Dependents to enroll for coverage, even if coverage was previously declined.

Loss of Other Coverage

The Plan will permit you or your Dependent(s) who lose other coverage to enroll under the terms of the Plan, with coverage to be effective on the event date, if the following conditions are met:

1. You and your Dependent(s) are eligible for coverage under the terms of this Plan;
2. You or your Dependent already had other coverage when the Plan was previously offered;
3. You stated in writing at such time that another source of coverage was the reason for declining enrollment; and
4. a. Coverage was not under a COBRA continuation provision and was terminated as a result of:

   (1) A loss of eligibility for the coverage, other than Medicaid or State Child Health Insurance Plan. A "loss of eligibility" includes, but is not limited to, a loss that is a result of legal separation, divorce, death, termination of employment, reduction in hours of employment, a child ceasing to qualify as an eligible dependent under the other plan, or the coverage is no longer being made available to a class of similarly situated individuals; or

   (2) Termination of all employer contributions towards such coverage.

   Coverage must be requested not later than 30 days after the loss of other coverage. When loss of eligibility is the result of meeting the overall lifetime maximum benefit, the 30 day Special Enrollment Period will begin the date the individual receives written notification of attaining or exceeding the lifetime limit.

   b. The person was covered under COBRA continuation coverage which was exhausted and the person requested enrollment not later than 30 days after the end of the COBRA coverage.

Acquiring a New Dependent

The Plan will permit a Special Enrollment Period for persons who become a Dependent through marriage, birth, adoption or placement for adoption. The Dependent Special Enrollment Period will be for 30 days following the actual event.

If you are eligible for enrollment, but not enrolled, you may also enroll at this time. In the case of the birth or adoption of a child, your spouse also may be enrolled as a Dependent, if your spouse is otherwise eligible for coverage but not already enrolled. If you enroll a Dependent during the 30-day Dependent Special Enrollment Period, coverage will become effective as of the date of birth, adoption or placement for adoption, or marriage.

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 become 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.

Late Enrollees

Late Enrollees are eligible to enroll for coverage only during the Plan's Annual Enrollment Period.

Qualified Medical Child Support Orders

The Plan Administrator will enroll for coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order or "National Medical Support Notice" ("NMSN") that is a "Qualified Medical Child Support Order" ("QMCSO") if such an individual is not already covered by the Plan as an eligible Dependent. Coverage will become effective on the first day of the month following the date the Plan Administrator has determined that such order meets the standards for qualification set forth below or upon the employee's completion of the eligibility Waiting Period, if later. If the employee is not currently enrolled in this Plan, the employee will also be enrolled as of such date.

"Alternate Recipient" means any child of a Covered Person who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Covered Person's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient will be treated as an eligible Dependent.

"Medical Child Support Order" means any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Covered Person's child or directs the Covered Person to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" means a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;

3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Covered Person or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Person or eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Covered Person and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice will be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";
2. a. Identifies either the specific type of coverage or all available group health coverage. If the City receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the City and the Plan Administrator will assume that all are designated;

   b. Informs the Plan Administrator that, if a group health plan has multiple options and the Covered Person is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and
3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Covered Persons and eligible beneficiaries without regard to this section, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator will, as soon as administratively possible:

1. Notify the Covered Person and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Covered Person and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator will:

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

   a. Whether the child is covered under the Plan; and

   b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator will:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

Participant Eligibility

A Participant eligible for coverage under the Plan will include an individual who meets the following conditions:

1. Is employed by the City on a regular full-time basis, is available to work a fully scheduled work week, has been in Active Service for the initial eligibility period outlined in the General Eligibility Provisions and has begun work for the City;
2. Is a Participant who extends coverage under COBRA; or
3. Qualifies under other classifications, as stated in the General Eligibility Provisions.

If you are an Eligible Employee who becomes employed by the City after the effective date of the Plan, your initial date of eligibility is outlined in the General Eligibility Provisions.

If your Dependent(s) meet the Plan's definition of a Dependent you will become eligible for Dependent Coverage on the latest of the following:

1. The date you become eligible for Participant Coverage; or
2. The date on which you first acquire a Dependent or the Dependent first becomes eligible for coverage.

If both you and your spouse are employed by the City, either you or your spouse, (but not both) may elect Dependent Coverage. If you choose to enroll for coverage as your spouse's Dependent, you are not eligible to also enroll for Single Coverage. If there are no eligible children, you and your spouse may each elect Single Coverage. If coverage is terminated on one of the individuals, this coverage may be transferred to the remaining spouse's coverage without loss of any benefits or coverage.

The Plan Sponsor may make special eligibility arrangements for new or separating employees when necessary to serve a valid business purpose.

Participant Effective Date

Your Participant Coverage under the Plan will become effective at 12:00 a.m. on the date of your eligibility, provided written application for coverage is made **on or within 30 days of such date.** All Dependent Coverage under the Plan will commence at 12:00 a.m. on the date such coverage is effective.

Participant Termination

Your coverage will automatically terminate at 12:00 midnight upon the earliest of the following dates:

1. Last day of the month in which termination of your employment occurs;
2. Last day of the month in which you cease to be an Eligible Employee as defined by this Plan;
3. Date of expiration of the last period for which you have made a contribution, in the event you fail to make any required contribution for coverage or last day of the month in which you file a written election to discontinue coverage;

   Note: If you elect to make your contribution for coverage on a pre-tax basis under the City's Section 125 Plan, you will be allowed to discontinue coverage only if permitted under IRS regulations.
4. Date the Plan is terminated, or with respect to any Participant benefits of the Plan, the date of termination of such benefits;
5. Date of your death;

6. Last day of the month in which you are on lay-off or an approved leave of absence, except as otherwise stated.

Upon the termination of coverage, there is no extension of any benefits under this Plan for any reason unless specifically noted in the Plan.

Participant Reinstatement

If your coverage terminates by reason of termination of employment, and your employment is reinstated with the City within a one-month period immediately following the date of such termination, you will be eligible for reinstatement of coverage on the date you resume employment. If you are rehired but not reinstated, you are not eligible for this provision.

The Waiting Period defined under the General Eligibility Provisions will not apply upon reinstatement. No benefits will be paid for expenses Incurred when coverage was not in force.

Dependent Eligibility

A Dependent will be considered eligible for coverage on the date you become eligible for Dependent Coverage, subject to all limitations and requirements of this Plan, and in accordance with the following:

1. Newborn children will be eligible for coverage from the moment of birth, **provided you properly enroll the child as a Dependent within 30 days of the child's date of birth.**

   If full Family coverage (including children) is in effect prior to the date of birth of the newborn, no further enrollment is necessary; however, the Plan Administrator should be notified in a timely manner. If you are covered as an employee with only one Dependent, you must enroll a new Dependent within 30 days.

2. An adopted child will be eligible for coverage on the date the child is legally adopted or placed with you in anticipation of adoption, provided the child is properly enrolled as a Dependent within 30 days.
3. A spouse will be considered an eligible Dependent from the date of marriage, provided the spouse is otherwise eligible and properly enrolled prior to the date of marriage, or within 30 days of the date of marriage. If an otherwise eligible spouse is not a resident of the same country as you, your spouse will be considered an eligible Dependent on the date he or she satisfies this residence requirement provided your spouse is properly enrolled within 30 days of such date.
4. A civil union partner will be considered an eligible Dependent when the requirements outlined in the section "Eligible Dependents" are met, provided the partner is enrolled within 30 days.
5. If a Dependent is acquired other than at the time of birth, due to a court order, decree or marriage, that Dependent will be considered an eligible Dependent from the date of such court order, decree or marriage, provided that this new Dependent is properly enrolled prior to or within 30 days of such an event and is otherwise eligible.
6. A Dependent who continues coverage under COBRA.

In order to enroll your eligible spouse and Dependent children, it will be necessary to comply with the Plan's rules and procedures to verify Dependent eligibility status.

Dependent Effective Date

If you file your written request for Dependent Coverage on a form approved by the Plan Administrator, your Dependent(s) will become covered at 12:00 a.m. as follows:

1. If you make such written request within 30 days of your earliest eligibility date, any person who is then your Dependent will become covered on the date your Participant Coverage begins.
2. If you acquire an eligible Dependent after your Participant Coverage begins, your Dependent will become covered on the date the Dependent becomes eligible (that is, the date of marriage, birth, adoption, court order or decree) provided the newly acquired spouse or child is enrolled for coverage within 30 days of such date. However, if full Family coverage is in effect prior to a newborn child's date of birth, the newborn will become covered immediately without specific enrollment required for that child.

If Dependent Coverage under the Plan is requested and you make such written request after the end of the 30-day period specified above or after your previous termination of Dependent Coverage, you may enroll your Dependent during an applicable Special Enrollment Period or during the Annual Enrollment Period.

Dependent Termination

Coverage for your Dependent(s) will automatically terminate at 12:00 midnight upon the earliest of the following dates:

1. Date of termination of your coverage under the Plan. However, if you are enrolled for Family coverage on the date of your death, coverage for your surviving Dependents will end on the last day of that calendar month;
2. Last day of the month in which the Dependent ceases to be an eligible Dependent under the Plan;
3. Last day of the month in which you cease to be in a class of Participants eligible for Dependent Coverage;
4. Date of expiration of the last period for which you have made a contribution, in the event you fail to make any required contribution for Dependent Coverage or last day of the month in which you file a written election to discontinue Dependent Coverage;

   Note: If you elect to make your contribution for coverage on a pre-tax basis under the City's Section 125 Plan, you will be allowed to discontinue coverage only if permitted under IRS regulations.
5. Date the Plan is terminated, or with respect to any Dependent benefit of the Plan, the date of termination of such benefit; or
6. Date the Dependent dies.

Upon the date of termination of coverage, there is no extension of any benefits under this Plan for any reason unless specifically noted in the Plan.

COORDINATION OF BENEFITS PROVISION

The coordination of benefits provision is intended to prevent payments of benefits which exceed expenses. It applies when a Covered Person is **also covered** by any **Other Plan or Plans**. When more than one coverage exists, one plan normally pays its benefits in full and the Other Plans pay a reduced benefit. Only the amount paid by this Plan will be charged against the Plan maximums.

This Plan coordinates benefits in the **traditional method** defined as follows: this Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the Other Plan or Plans, will not exceed 100% of Allowable Expenses.

The coordination of benefits provision applies whether or not a claim is filed under the Other Plan or Plans. If needed, authorization must be given to this Plan to obtain information as to benefits or services available from the Other Plan or Plans, or to recover overpayment. All benefits under this Plan are subject to this provision.

There is no coordination of benefits within this Plan. Coordination of benefits is applicable only with OTHER PLANS.

Definitions

The term **"Plan"** as used herein will mean any plan providing benefits or services for or by reason of medical or dental treatment, whose benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group, whether on an insured or uninsured basis, including but not limited to:
    a. Hospital indemnity benefits; and
    b. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity benefits at the time of claims;
2. Hospital or medical service organizations on a group basis, group practice, and other group pre-payment plans;
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
4. A licensed Health Maintenance Organization (H.M.O.);
5. Any coverage under a governmental program, and any coverage required or provided by any statute;
6. Group motor vehicle insurance including, without limitation, medical reimbursement coverages;
7. Individual motor vehicle insurance coverage on a motor vehicle leased or owned by the City;
8. Individual motor vehicle insurance under "no-fault" coverage, personal Injury protection coverage, medical payments or reimbursement coverage, financial responsibility coverage, "no-fault" medical payments coverage, underinsured coverage, uninsured coverage and any other medical payment coverage;
9. Any coverage under labor-management trustee plans, union welfare plans, Employer organization plans, or employee benefits organization plans, and similar medical payable coverage;
10. Medical reimbursement coverage available under homeowners' insurance, or any other type of Insurance policy;
11. "School" or team insurance or any coverage for students which is sponsored by or provided through a school or other educational institution.

The term "Other Plan" will 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 “Allowable Expenses” means any Covered Expense under this Plan. Any expense excluded under this Plan in the absence of coordination of benefits will also be excluded under this Plan in the presence of coordination of benefits, regardless of whether or not the expense is covered by any Other Plan. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of these services rendered will be deemed to be both an Allowable Expense and a benefit paid. In the case of an HMO (Health Maintenance Organization) or DMO (Dental Maintenance Organization) plan, this Plan will not consider any charges in excess of what an HMO or DMO provider has agreed to accept as payment in full. Further, when an HMO or DMO is primary and the Covered Person does not use an HMO or DMO provider, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO or DMO had the Covered Person used the services of an HMO or DMO provider.

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

Coordination Procedure

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits payable under all plans will not exceed the total of Allowable Expenses Incurred during any Claim Determination Period.

Payments

Each Plan makes its claim payment according to the following order if Medicare is not involved:

1. If a plan contains no provision for coordination of benefits, it pays before all other plans.
2. If a person is a covered employee under one plan, and a covered dependent under another plan, the plan that covers the person as an employee is the primary plan.
3. If a child is covered under more than one plan and the parents are not legally separated or divorced, the primary plan is:
    a. The plan of the parent whose birthday falls earlier in the calendar year will be the primary plan; or,
    b. If both parents have the same birthday, the plan which has covered the parent the longest will be the primary plan.

    If the other plan does not have this rule but instead has a rule based upon the gender of the parent, the rule in this plan will override the rules of the other plan in determining the order of benefits.
4. If a child is covered under more than one plan and the parents are legally separated or divorced, the primary plan is determined as follows:
    a. The plan of the natural parent having responsibility for the child’s health care expenses by court decree pays first. If the court decree splits the responsibility equally between the divorced parents, the primary plan is the plan of the parent whose birthday, excluding year of birth, falls earlier in the calendar year. If both parents have the same birthday, then the plan which has covered the child the longest will be the primary plan;
    b. in the absence of a court decree, -
        (1) The plan of the natural parent having legal custody pays; then,
        (2) The plan of the spouse (if any) of the natural parent with legal custody pays; then,
        (3) The plan of the natural parent without legal custody pays last.
5. If an adult child is employed and/or married, the plan covering the child as an employee is the primary plan, the plan covering the child as a spouse is secondary, and the plan covering the child as a dependent child will pay third. A plan that pays third will only pay benefits if there are unpaid allowable expenses after the first and second plans have paid.
6. If a person is a covered active employee under one plan and a covered retired or laid off employee under another plan, the plan that covers the person as an active employee or a dependent of an active employee is the primary plan.

7. If a person covered under a right of continuation pursuant to federal or state law is also covered under another plan, the plan that covers the person as an employee, member or subscriber is the primary plan and the plan providing continuation coverage is secondary.

8. If the order described above fails to establish the order of payment, then the plan which the person has been covered for the longest period of time is the primary plan.

9. In the event that you or your Dependent is covered by another group dental plan which, by its terms:

    a. The plans cannot agree on the primary versus secondary order; or

    b. Provides that it is secondary to other dental plans, and the provisions of this Plan would make coverage under this Plan secondary to other applicable dental plan coverage;

    Then the payments by this Plan will automatically be reduced by 50% and will be paid to the dental provider or the employee as applicable and this Plan will have no further obligations with respect to such dental expenses.

Regardless of the order outlined above, in the event a Covered Person is injured in any way due to an Accident, and any no-fault, personal injury protection ("PIP") and/or medical payments coverage(s) are found to be available, these First Party coverages are primary and must be paid out (exhausted) in their entirety before a payment under this Plan is to be considered eligible.

The Plan Administrator has the right:

1. To obtain or share information with an insurance company, Plan Administrator or other organization regarding coordination of benefits without the claimants consent;

2. To require that the claimant provide the Plan Administrator with information on such Other Plans so that this provision may be implemented; and

3. To refund the amount due under this Plan to an insurer, plan or other organization if this is necessary, in the Plan Administrator's opinion, to satisfy the terms of this provision.

Accumulation of Benefit Savings

This Plan does not accumulate benefit savings in a secondary payer capacity to be used to cover the cost of previous Deductibles, Coinsurance and ineligible expenses.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plan or Plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, the Plan will be fully discharged from liability.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in absence of this provision.

Right of Recovery

Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of this provision, the Plan will have the right to recover such payments, to the extent of such excess, in accordance with the provisions of this Plan.

PRIVACY STANDARDS

1. Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

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:

a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

(1) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, will be given access to the PHI to be disclosed:

Human Resources Manager
Staff designated by Human Resources Manager
Chief Financial Officer
Plan Auditor
Privacy Officer
Any other individual named in the City's HIPAA Compliance documents

(2) The access to and use of PHI by the individuals described in subsection (1) above will be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

(3) In the event any of the individuals described in subsection (1) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions will be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and will be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

k. 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).

l. 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).

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

4. Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or Professional Benefit Administrators, Inc., to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures will be made in accordance with the Privacy Standards.

5. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan will comply with the Privacy Standards.

SECURITY PRACTICES

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:

1. Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;

3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI;

4. Report to the Plan any Security Incident of which it becomes aware;

5. 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

6. 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).

Any terms not otherwise defined in this section will have the meanings set forth in the Security Standards.

CLAIM PROCEDURES

The procedures outlined below must be followed by Covered Persons ("claimants") to obtain payment of health benefits under this Plan. “Health benefits” are considered to include dental benefits.

Claims

All claims and questions regarding claims should be directed to Professional Benefit Administrators, Inc. (PBA). The Plan Administrator will be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Plan Document and Summary Plan Description may be delegated to Professional Benefit Administrators, Inc. (PBA); provided, however, that Professional Benefit Administrators, Inc. (PBA) is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each claimant claiming benefits under the Plan will be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit or disability is covered under the Plan. If the Plan Administrator in its sole discretion determine that the claimant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the claimant fails to furnish such proof as is requested, no benefits or further benefits will be payable under the Plan.

Under the Plan, there are four types of health claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims. A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

   A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-Urgent Care determinations could seriously jeopardize the life or health of the claimant or the claimant’s ability to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant’s medical Condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

   It is important to remember that, if a claimant needs medical care for a Condition which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The claimant should obtain such care without delay.

   Further, if the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

2. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

   a. The Plan determines that the course of treatment should be reduced or terminated; or

   b. The claimant requests extension of the course of treatment beyond that which the Plan has approved.

   If the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

3. Post-service Claims. A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Claims Must Be Filed

Claims must be filed with Professional Benefit Administrators, Inc. (PBA) within 6 months of the date charges for the service were Incurred. However, should the Plan be terminated, claims must be filed within 90 days following the date of termination. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Charges are considered Incurred when treatment or care is given or supplies are provided. **Claims filed later than that date will be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by Professional Benefit Administrators, Inc. (PBA) in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by Professional Benefit Administrators, Inc. (PBA), together with a properly completed standard medical billing statement (such as Form HCFA, Form UB92, or UB04) or ADA Dental Claim Form:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges and repricing information;
6. The name of the Plan;
7. The name of the covered employee; and
8. The name of the patient.

Upon receipt of the appropriate information, the claim will be deemed to be filed with the Plan.

Professional Benefit Administrators, Inc. (PBA) will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by Professional Benefit Administrators, Inc. (PBA) within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator will notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims.
    a. If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
    b. If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:
        (1) The Plan's receipt of the specified information; or
        (2) The end of the period afforded the claimant to provide the information.
2. Pre-service Non-urgent Care Claims.
    a. If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

b. If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the claimant (if additional information was requested during the extension period).

3. Concurrent Claims.

   a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, the claimant will be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

   b. Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.

   c. Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

4. Post-service Claims.

   a. If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

   b. If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the claimant will be notified of the determination by a date agreed to by the Plan Administrator and the claimant.

5. Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care Claims.

6. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

7. Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

8. Calculating Time Periods. The period of time within which a benefit determination is required to be made will begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator will provide a claimant with a notice, either in writing or electronically (or, in the case of Pre-service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Plan Document and Summary Plan Description upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures;
5. 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;
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request);
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request; and
9. In a claim involving Urgent Care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate Named Fiduciary of the Plan, who will be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes 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 prior benefit determination;
5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, 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;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

7. That a claimant will 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 in possession of the Plan Administrator or Professional Benefit Administrators, Inc. (PBA); information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; and
8. In an Urgent Care Claim, for an expedited review process pursuant to which:
    a. A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and
    b. All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

First Appeal Level

Requirements for First Appeal

The claimant must file the first appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) within 180 days following receipt of the notice of an adverse benefit determination. For Pre-service Urgent Care Claims, if the claimant chooses to orally appeal, claimant may telephone:

Professional Benefit Administrators, Inc. (PBA) at 630-655-3755

To file an appeal in writing, the claimant's appeal must be addressed as follows:

Professional Benefit Administrators, Inc. (PBA)
900 Jorie Boulevard, Suite 250
Oak Brook, IL 60523-3827
Attn: Claim Appeals

Upon receipt, an appeal will be deemed to be filed with the Plan provided all of the information listed below is included.

It is the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/claimant;
2. The Employee/claimant's individual identification number printed on the Plan I.D. Card;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal**;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that, in the case of a health claim, the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal

The Plan Administrator will notify the claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims. As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the appeal.

2. Pre-service Non-urgent Care Claims. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
3. Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims. Within a reasonable period of time, but not later than 30 days after receipt of the appeal.
5. Calculating Time Periods. The period of time within which the Plan's determination is required to be made will begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal

The Plan Administrator will provide a claimant with notification, with respect to Pre-service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Plan Document and Summary Plan Description on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. 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;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request;
7. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
8. A description of the Plan's review procedures and the time limits applicable to the procedures;
9. For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claims; and
10. 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."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator will provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal

Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the claimant has 60 days to file a second appeal of the denial of benefits. The claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the claimant's second appeal must be in

writing (although oral appeals are permitted for Pre-service Urgent Care Claims) and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal

The Plan Administrator will notify the claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims. As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the second appeal.
2. Pre-service Non-urgent Care Claims. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.
3. Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims. Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.
5. Calculating Time Periods. The period of time within which the Plan's determination is required to be made will begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan's response to a second appeal as a first appeal, except for:

1. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is needed;
2. A description of the Plan's review procedures and the time limits applicable to the procedures; and
3. For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claim.

See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on the second appeal, the Plan Administrator will provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

Decision on Second Appeal to be Final

If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate Named Fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.**

Appointment of Authorized Representative

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from Professional Benefit Administrators, Inc. (PBA). However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the claimant's medical Condition to act as the claimant's authorized representative

without completion of this form. In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.

COBRA CONTINUATION COVERAGE

Note: A civil union partner will be eligible for COBRA on the same basis as a federally recognized spouse. As such, civil union partner will be a Qualified Beneficiary entitled to independent COBRA election rights, and termination or dissolution of a partnership will be considered a Qualifying Event for the partner and any enrolled Dependent children. Wherever the term "spouse" is used in this section, an eligible civil union partner is also meant to be included.

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if you or your Dependents fail to make timely payment of premiums. You should check with your employer to see if COBRA applies to you and your Dependents.

Any questions regarding COBRA Continuation Coverage should be addressed to the Plan Administrator through the Human Resources Department. The Plan Administrator of this Plan is:

The City of Lake Forest
800 North Field Drive
Lake Forest IL 60045
(847) 234-2600

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your employer's plan) are not considered for continuation under COBRA.

What is a Qualifying Event?

Specific Qualifying Events are listed below. 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.

If you are a Covered Employee (meaning that you are an employee and are covered under the Plan), you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
   Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.
5. 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 happens:

1. The parent-Covered Employee dies;
2. The parent-Covered Employee's hours of employment are reduced;

3. The parent-Covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-Covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
   Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

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 the employer sponsoring the Plan, 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 also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan. If this Plan does not provide for retiree coverage this paragraph does not apply.

The employer must give notice of some Qualifying Events

When the Qualifying Event is the end of employment, reduction of hours of employment, death of the Covered Employee, commencement of a proceeding in bankruptcy with respect to the employer, or the Covered 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

Each Covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a Covered Employee (or former employee) from his or her spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a dependent child under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of Continuation Coverage; and
5. Notice that a Qualified Beneficiary, with respect to whom a notice described in paragraph (4) above has been provided, has subsequently been determined by the SSA to no longer be disabled.

NOTE: A "Notice of Change" form is available, free of charge, from the Plan Administrator and must be used when providing the notice.

Deadline for providing the notice

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
3. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described in (4) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;
2. The date on which a Qualifying Event occurs;

3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or
2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if you are electing COBRA Continuation Coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who can provide the notice

Any individual who is the Covered Employee (or former employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Covered Employee (or former employee) or Qualified Beneficiary, may provide the notice, and the provision of notice by one individual will satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required contents of the notice

The notice must contain the following information:

1. Name and address of the Covered Employee or former employee;
2. If you already are receiving COBRA Continuation Coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;
3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the Covered Employee or former employee, death of the Covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status);
4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
5. In the case of a Qualifying Event that is Medicare entitlement of the Covered Employee or former employee, date of entitlement, and name(s) and address(es) of spouse and dependent child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a dependent child's cessation of dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible dependent (for example, attained limiting age or other);
7. In the case of a Qualifying Event that is the death of the Covered Employee or former employee, the date of death, and name(s) and address(es) of spouse and dependent child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;

9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or legal separation or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or legal separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the Covered Employee (or former employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within 14 days of receiving the notice of your Qualifying Event. You then have 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. **If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.**

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.

If the Qualified Beneficiary is totally incapacitated and is not legally competent to make an election for COBRA continuation coverage, the 60 day election period is tolled until such time as the Qualified Beneficiary is able to make an election or a guardian or legal representative is appointed who is able to make the election on behalf of the Qualified Beneficiary.

In the event that the Plan Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the Plan Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event; however, if the first Qualifying Event is the Covered Employee's entitlement to Medicare benefits, followed by termination or reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than the Covered Employee ends on the later of (i) 36 months after the date the Covered Employee became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the Covered Employee (or former employee), the Covered Employee's (or former 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 a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the Covered 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 (for reasons other than gross misconduct) or reduction of the Covered 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 COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and you notify the Plan Administrator as set forth above, 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 COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Second Qualifying Event extension of 18-month period of COBRA 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 properly is given to the Plan as set forth above. This extension may be available to the spouse and any dependent children receiving COBRA Continuation Coverage if the Covered Employee or former employee dies, or gets divorced or legally separated, if the dependent child stops being eligible under the Plan as a dependent child, or becomes entitled to Medicare benefits (under Part A, Part B, or both), **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.**

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date your employer ceases to provide a group health plan to any employee;
2. The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
3. The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules); or
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator.

Current Addresses

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.

DEFINITIONS

Certain words and phrases used in this Summary Plan Description are listed below with the definition or explanation of the manner in which the term is used for the purpose of this Plan. **The following definitions are not an indication that charges for particular services or supplies are eligible for payment under the Plan; please refer to the appropriate sections of the Summary Plan Description for that information.**

Accident

"Accident" means an unintentional or unexpected happening which:

1. Causes Injury to the physical structure of the body;
2. Results from an external agent or trauma;
3. Is definite as to time and place; and
4. Happens involuntarily, or if it is the result of a voluntary act, entails unforeseen consequences.

"Accident" does not include a hernia of any kind, harm resulting from a disease, Illness or allergic reactions, with the exception of insect venom reactions.

Active Service

"Active Service" means a Participant is employed by the City as an Eligible Employee as defined in the General Eligibility Provisions. Such work may occur either at the usual place of business of the City or at a location to which the business of the City requires the Participant to travel, and for which he receives regular earnings from the City. An employee will be deemed to be in Active Service if he is absent from work due to a health factor.

Annual Enrollment Period

"Annual Enrollment Period" means the time period set forth in the General Eligibility Provisions.

Calendar Year

"Calendar Year" means a period of time commencing on January 1, and ending on December 31, in the same given year.

City

"City" is as defined in the "Introduction" section.

Claims Administrator

"Claims Administrator" means the firm employed by the Plan Administrator to provide ministerial services in connection with the operation of the Plan and any other function, including the processing and payment of claims.

Close Relative

"Close Relative" means a person who is related to the Covered Person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother and stepsister), child (includes legally adopted or stepchild), grandfather or grandmother.

COBRA

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance

"Coinsurance" means that portion of Eligible Expenses to be paid by the Plan and the Participant in accordance with the coverage provisions stated in the Plan. It is the basis used to determine the amount of Covered Expenses which are to be paid by the Participant.

Condition

See definitions of "Illness" and "Injury."

Cosmetic Procedure or Cosmetic

"Cosmetic Procedure" or "Cosmetic" means a procedure or treatment performed solely or primarily for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function.

Covered Charges or Covered Expenses

"Covered Charges" or "Covered Expenses" means the provider's charge for services rendered to the Covered Person for necessary treatments, services or supplies, which are considered Usual and Customary, are subject to Coinsurance and Deductibles, and are not specifically excluded under the Plan.

Covered Person

"Covered Person" means any Participant or Dependent. "Covered Person" will be deemed to include, where appropriate, a COBRA continuee or a person who qualifies under other classifications set forth in the General Eligibility Provisions, who meets the eligibility requirements of coverage as specified in this Plan, and is properly enrolled in the Plan.

Craniomandibular Disorder

"Craniomandibular Disorder" means pain, muscular spasm, grinding, clicking, swelling, numbness, stiffness, headache or other pathological Condition which creates a loss or decrease of function, involving chewing muscles of the upper and lower jaws, the postural muscles of the upper and lower jaws and of the neck, and the nerves, muscles, ligaments, glands and bones of the face, skull, neck and spine.

Deductible

"Deductible" means a specified dollar amount of Covered Expenses which must be Incurred during a Calendar Year (unless otherwise stated in a benefit schedule) before any other Covered Expenses can be considered for payment according to the applicable benefit percentage.

Dependent

"Dependent" is as defined under the section "General Eligibility Provisions – Eligible Dependents".

Dependent Coverage

"Dependent Coverage" means eligibility under the terms of the Plan for benefits payable as a consequence of Eligible Expenses Incurred for an Illness or Injury of a Dependent.

Eligible Expenses

See definition of "Covered Charges" or "Covered Expenses."

Employer

"Employer" is the City, as defined in the "Introduction" section.

Enrollment Date

"Enrollment Date" means the earlier of the effective date of coverage or the first day of the Waiting Period, if any, for coverage. The Enrollment Date for Late Enrollees or individuals enrolling during a Special Enrollment Period is the actual date of coverage.

Family

"Family" means a Participant and eligible Dependents.

Felonious Act

"Felonious Act" means a crime or offense which carries with it the punishment associated with a felony conviction, as determined by common law or statute within the presiding jurisdiction of law enforcement. An occurrence of driving under the influence of a drug or alcohol is not considered a "Felonious Act" under this Plan.

Health Breach Notification Rule

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

HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

Illness

"Illness" means a disorder or disease of the body or mind, or pregnancy as classified in the ICD.9.CM Manuals (or updated version). All Illnesses due to the same cause, or to a related cause, will be deemed to be one "Illness."

Incurred

"Incurred" means the date when a service is performed, a supply is provided or a purchase is made. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Injury

"Injury" means a Condition caused by an Accident which results in damage to the Covered Person's body.

Legal Guardianship

"Legal Guardianship" means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

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 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.

Medicare

"Medicare" means the program of health care established by Title XVIII of the Social Security Act of 1965, as amended.

Named Fiduciary

"Named Fiduciary" means the City, which has the authority to control and manage the operation and administration of the Plan.

Participant

"Participant" means a person directly employed full-time in the regular business of, and compensated for services by, the Employer, who is eligible for, has elected and has enrolled for Participant Coverage.

Participant Coverage

"Participant Coverage" means eligibility under the terms of the Plan for benefits payable as a consequence of an Injury or Illness of a Participant.

Physician

"Physician" will include the following health care providers:

A legally licensed medical or dental doctor or oral surgeon, Physician assistant, to the extent they, within the scope of their license, are permitted to perform the services provided in this Plan.

Plan

"Plan" means the City's employee welfare benefit plan, which is described in this Summary Plan Description.

Plan Administrator

"Plan Administrator" means the City.

Summary Plan Description

"Summary Plan Description" means this Plan Document and Summary Plan Description, which constitutes both the Plan Document and the "Summary Plan Description" or "SPD".

TMJ Dysfunction

"TMJ Dysfunction" means pain, swelling, clicking, grinding, popping, dislocation, locking, malposition, bite discrepancies or other pathological Conditions which create a loss or decrease of function in, around or caused by one or both of the jaw joints.

Usual and Customary

*"*Usual and Customary" refers to the designation of a charge, as determined by any nationally recognized database or any other research firm which the Claims Administrator utilizes, as being the usual charge made by a Dentist or Physician or other provider of services, supplies, medications or equipment that does not exceed the general level of charges made by other providers furnishing such care or treatment within the same area. The term "area" in this definition means a county or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature or severity of the Condition being treated and any complication or unusual circumstances which require additional time, skill or expertise.

Waiting Period

"Waiting Period" means the amount of time that must pass before an individual is eligible to be covered for benefits under the terms of the Plan.

GENERAL PLAN INFORMATION

Name of Plan

The name of the Plan is The City of Lake Forest Dental Plan.

Plan Sponsor

The Plan Sponsor is the City. The Plan Sponsor will have the authority to amend and terminate the Plan, determine its policies, appoint and remove other supervisors, fix their compensation and exercise general administrative authority over them.

Plan Sponsor's Employer Identification Number

The Plan Sponsor's Employer Identification Number (EIN) is 36-6005960.

Named Fiduciary, Plan Administrator

The Named Fiduciary and Plan Administrator is the City. The Plan Administrator may delegate certain ministerial functions which do not require the use of discretionary authority to the Claims Administrator.

Plan Year

January 1 through December 31

Plan Number

501

Plan Type

Dental

Contributions to the Plan

Contributions are to be made on the following basis:

The Plan Sponsor will, from time to time, evaluate the costs of the Plan and determine the amount to be contributed (if any) by each Participant, in its sole discretion. Any employee contributions are used by the Plan for the payment of claims.

In the event that the Plan Sponsor terminates the Plan, then as of the effective date of termination, the Plan Sponsor and Participants will have no further obligation to make additional contributions to the Plan for claims Incurred after the date of termination.

Plan contributions for PARTICIPANT and DEPENDENT Coverage are shared by the City and employee.

If you elect to have your contribution for coverage deducted from your pay on a pre-tax basis under the City's Section 125 plan, you will only be allowed to change your coverage election during the annual Section 125 election period or, if sooner following a change in family status as defined under IRS regulations.

Contributions and Benefits

The tax treatment of contributions and/or benefits under this Plan is governed by Section 105(b) and Section 152 of the Internal Revenue Code and is the sole responsibility of the Participant.

Effective Date

The effective date of the Plan is January 1, 2000.

Claims Administrator

The Claims Administrator of the Plan is Professional Benefit Administrators, Inc. ("PBA"), 900 Jorie Boulevard, Suite 250, Oak Brook, Illinois 60523-3827.

The City, Plan Sponsor, Plan Administrator and Agent for Service of Process

The agent for service of process is:

Plan Administrator
The City of Lake Forest
800 North Field Drive
Lake Forest IL 60045
(847) 234-2600

The Plan is a distinct legal entity separate from the City. As such, legal notice may be filed with, and legal process served upon, the Plan Administrator.

Plan Construction, Type of Administration and Funding

This Summary Plan Description will be construed in accordance with the laws of the state in which the Plan Sponsor is located.

This is a self-funded Plan with a Claims Administrator. The Plan Administrator is responsible for all claims decisions, and the Plan Sponsor is responsible for providing funds for the payment of the claims out of its general assets.

All Plan terms will be applied on a gender neutral basis. Masculine pronouns used in this Summary Plan Description will include masculine or feminine gender unless the context indicates otherwise.

Wherever any words are used herein in the singular or plural, they will be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

Purpose

The purpose of this Summary Plan Description is to set forth the provisions of the Plan which provide for the payment or reimbursement of a portion of the eligible dental expenses. The Plan Sponsor's purpose in establishing the Plan is to help to offset, for Eligible Employees, the economic effects arising from a dental expense. To accomplish this purpose, the Plan Sponsor and the Plan Administrator must be cognizant of the necessity of containing dental costs through effective plan design, and of abiding by the terms of the Summary Plan Description, to allow for allocation of the resources available to help those individuals participating in the Plan to the maximum feasible extent.

GENERAL PROVISIONS

Amendments or Changes

The terms of this Plan will not be amended or changed except as provided below under the section entitled "Amending and Terminating the Plan."

Plan Is Not A Contract

This Plan will not be deemed to constitute a contract of employment, give any Participant the right to be retained in the service of the City or interfere with the right of the City to discharge or otherwise terminate the employment of any Participant.

Protection Against Creditors

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same will be void. If the Plan Administrator finds that such an attempt has been made with respect to any payment due or to become due to any Participant (or former Participant), the Plan Administrator, in its sole discretion, may terminate the interest of such person. In such case, the Plan Administrator will determine how to apply the payment to the benefit of the Participant (or former Participant) or his/her estate. Any such application shall be complete discharge of all liability with respect to such benefit payment.

Free Choice of Provider and Treatment

The Covered Person has free choice of any Dentist, Physician or surgeon, and the Physician-patient relationship will be maintained.

Alternate Care and Treatment

Alternate forms of care and treatment, which can be provided without impairing the quality of care, if recommended by utilization management, and if approved by the Plan Administrator can be considered a Covered Charge. Alternate treatment or care which is not included in the Plan, is included in the Plan but is limited, or is included in the Plan but on a basis that differs from the care and treatment now recommended, will be payable under the Plan on the same basis as the care and treatment for which they are substituted if it can be shown to be cost effective. This is subject to the approval of the Plan Administrator, Covered Person, the Covered Person's Family, and the Attending Dentist or Physician.

This provision is not intended to override the Experimental or Investigational treatment exclusion or lifetime maximum contained in the Plan.

Workers' Compensation Not Affected

This Plan is not in lieu of, and does not affect, any requirement for coverage by workers' compensation insurance.

This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any workers' compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that the Participant received or is eligible to receive workers' compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement the Participant receives from workers' compensation. The Plan will exercise its right to recover against the Participant.

A Participant is required to notify the Plan Administrator immediately when a claim for coverage under workers' compensation is filed if a claim for the same Injury or Illness is or has been filed with this Plan.

Personnel Policies

The Plan is intended to automatically comply with the Employer's current established written personnel policies regarding waiting periods, continuation of coverage or reinstatement of coverage during the following situations regardless of whether or not the Plan has been specifically amended or modified: Employer certified disability, an approved leave of absence, layoff, reinstatement, hire or rehire. The Plan will at all times comply with the Family and Medical Leave Act (FMLA).

Rights in Recovery

Whenever payments have been made by the Plan Administrator with respect to allowable expenses in excess of the amount of payment necessary to satisfy the intent of this Plan, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to recover such excess payments. Further, the Plan Administrator reserves the right to deduct the amount of any excess payment from future benefits to which a Participant or any of his covered Dependents may become entitled. This right of recovery also applies when a Covered Person, or any plan that pays benefits for which benefits are also paid by the Plan, receives duplicate payments under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

Physical Examination/Consultation/Peer Review

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

The Plan Administrator also has the right to seek and utilize the professional opinion of consultants, peer review and other such entities for the purpose of determining the eligibility of both individuals and claims under this Plan. The expenses related to these services will be considered an eligible expense under this Plan, but only for a Covered Person.

Legal Proceedings

No action at law or in equity shall be brought to recover from the Plan prior to the expiration of 90 days after all administrative remedies under the Plan have been exhausted, nor will such action be brought at all unless brought within one year from the time all administrative remedies under the Plan have been exhausted.

Conformity With Law

This Plan will be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Summary Plan Description. It is intended that the Plan will conform to the requirements of Federal civil rights laws, as it applies to group health plans, as well as any other applicable law.

Rescission

The Plan may rescind coverage for a Covered Person if the individual (or a person seeking coverage on behalf of the individual):

1. Performs an act, practice or omission that constitutes fraud; or
2. Makes an intentional misrepresentation of a material fact.

Both such items are prohibited by the terms of this Plan. The Plan Administrator will determine whether an action or inaction constitutes fraud or an intentional misrepresentation of a material fact.

The Plan will provide 30 days advance written notice of any rescission. The rescission can affect the Covered Person's entire family, even if only one individual committed the fraud or misrepresentation.

Examples of fraud include, but are not limited to, the following:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;
2. Attempting to file a claim for a Covered Person for services which were not rendered or drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

Plan Administration

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of Professional Benefit Administrators, Inc. to provide certain claims processing and other technical services.

An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

When the City acquires a new unit, whether through acquisition, merger or any other transaction, the employees of the new unit may become eligible under this Plan, waiving any and all Waiting Periods. The Plan Sponsor maintains the right to make the election to do this on an acquisition, merger or transaction basis, as business needs dictate.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. If this Plan is subject to, in whole or in part, one or more collective bargaining agreements, the Plan is intended to automatically comply with any such agreement that has valid bearing on this Plan, whether or not the Plan has been specifically amended or modified. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. In the event of administrative error or oversight, the Plan Administrator has the right to determine the effective date or termination date of coverage. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, will receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

The City may make special eligibility arrangements for new or separating employees when necessary to serve a valid business purpose.

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting;
10. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;

11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Right to Audit or Review

Once a written claim for benefits is received, the Claims Administrator, acting on the authority and discretion of the Plan Administrator, may elect to have such claim reviewed or audited for accuracy and reasonableness of charges as part of the adjudication process. This process may include, but not be limited to, identifying:

1. Charges for items/services that may not be covered or may not have been delivered or performed,
2. Duplicate charges or billing mistakes,
3. Charges beyond the Usual and Customary guidelines as determined by the Plan,
4. Charges that have been unbundled, up-coded or otherwise coded inappropriately based on industry accepted practices or guidelines; and,
5. Charges for items/services that are determined to be excessive or beyond that which is generally accepted as being Necessary to treat or diagnose a dental Condition.

Any charge that is determined to be inaccurate or excessive by the Plan Administrator as a result of a claim review or audit will not be deemed a Covered Charge under this Plan.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which will be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination will be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action will be taken by the sole proprietor, in his own discretion.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan will become effective as of a date established by the Plan Sponsor. Contributions by the Plan Sponsor will continue to be issued for the purpose of paying benefits under this Plan with respect to claims arising before such termination.

Indemnification of Employees

No director, officer or employee of the City or the Claims Administrator will incur any personal liability for the breach of any responsibility, obligation or duty in connection with any act done or omitted to be done in good faith in the administration or management of the Plan; and each such director, officer and employee will be indemnified and held harmless by the City from and against any such liability, including all expenses reasonably Incurred in their defense if the City fails to provide such defense.

Assignment of Benefits

Benefits for dental expenses covered under this Plan may be assigned by a Participant to the provider; however, if those benefits are paid directly to the Participant, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant and the assignee, has been received before the proof of loss is submitted.

Clerical Error

Clerical error on the part of the Plan Administrator or Claims Administrator in keeping the records in connection with a Participant's coverage will not invalidate coverage otherwise in force, nor continue coverage otherwise terminated.

Manuals

Manuals and reference material used by the Plan in order to determine the appropriate administrative procedures, appropriate diagnosis, Usual and Customary allowances and Medical Necessity of claims submitted in compliance with this Summary Plan Description include, but are not limited to, the following:

1. ICD.9.CM (or updated version)
2. Usual and Customary Data Bases, Fee Schedules and Claims Edit Programs
3. 1964 California Relative Value Study (C.R.V.S.)
4. CPT 4 (or updated version)
5. Physician's Desk Reference
6. Merck Manual
7. Taber's Cyclopedic Medical Dictionary
8. The Kennedy Series Medical/Disability and Dentistry Handbooks
9. The Medical Disability Advisor
10. The Hayes Manuals
11. The Trilogy Consulting Group Manuals (as modified by PBA administrative memos)
12. Others as developed or needed
13. Red Book or other NDC References.

Provision Enforcement

No failure to enforce any provision of this Plan will affect the right thereafter to enforce such provision, nor will such failure affect the right to enforce any other provision of this Plan.

Severability

If any provision within the Plan Document is found to be invalid or illegal, that finding only applies to those such provisions and such a finding will not have any affect or change the obligations of the parties as to the remaining sections and be severable.

Section Titles

Section titles are for convenience of reference only, and are not to be considered in interpreting this Plan.

Foreign Claims

In the event a Covered Person incurs a Covered Expense in a foreign country due to an unexpected Illness or Injury, the Covered Person will be responsible for providing the following information to the Claims Administrator before reimbursement of any benefits due are payable.

1. The claim form, provider invoice and any documentation required to process the claim must be submitted in the English language.
2. The charges for services must be converted into U.S. dollars.
3. Proof that the bills have been paid. Benefits cannot be assigned to a non-U.S. provider.

A current published conversion chart, validating the conversion from the foreign country's currency into U.S. dollars, must also be submitted with the claim.

Unclaimed Payments

Any benefit payment issued under the Plan that is not cashed by the payee within the 12-month period immediately following its date of issue will be considered void and will only become a Plan liability upon receipt of the employee's written request for re-issuance. Such request must be made within the 24-month period immediately following the date the benefit payment was issued. Any request that is filed later will be denied.