

Plan Endorsement #11-SP

EFFECTIVE DATE January 1, 2026

NAME OF PLAN Government Insurance Network Employee Benefits Plan

The following wording is hereby added to the Plan:

Government Insurance Network, of Chicago, IL hereby maintains a plan for payment of certain expenses for the benefit of its eligible employees known as the Government Insurance Network Employee Benefits Plan (Plan). The attached document serves as the summary plan description, plan description and plan document for the Plan.

Government Insurance Network assures its covered members that during the continuance of the Plan all benefits herein after described shall be paid to or on behalf of them in the event they become eligible for benefits.

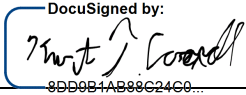
The Plan is subject to all the terms, provisions, and conditions recited on the following pages hereof. The Plan is not in lieu of and does not affect any requirements for coverages by Workers' Compensation Insurance. This Plan is not subject to Employee Retirement Income Security Act of 1974 (ERISA). To the extent that a court of law determines otherwise, the Plan shall be deemed to be automatically amended to incorporate the applicable ERISA provisions where necessary.

Certain Illinois insurance mandates apply to insurance policies and managed care plans regulated by the Illinois Department of Insurance. To the extent any such mandate applies to an insured component incorporated into this Plan or is otherwise applicable to the Plan by law, benefits will be administered in accordance with applicable law and the applicable Benefit Booklet(s). To the extent a mandate does not apply to a self-funded benefit, the Plan may nevertheless adopt comparable provisions by Plan amendment or administrative practice as determined by the Administrator.

Government Insurance Network has caused this Plan to take effect as of 12:01 A.M. Central Time on January 1, 2026 at Chicago, IL.

All other provisions of the Plan remain unchanged.

APPROVED AND ATTESTED:

BY  TITLE Village Administrator

DATE 6/16/2026 | 07:57 PDT

Government INSURANCE NETWORK

111 North Canal, Suite 550

Chicago, IL 60606

Phone: (312) 625-5616

This booklet describes the Medical, Dental, Vision, Life, AD&D and Voluntary Life and AD&D benefits for Eligible Employees of Government Insurance Network.

**Effective
January 1, 2026**

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KEY INFORMATION

PLAN ADMINISTRATOR/ PLAN SPONSOR CONTACT INFORMATION:

Government Insurance Network
C/O Marsh & McLennan Agency, LLC
111 N Canal, Suite 550
Chicago, IL 60606

PLAN NAME:

Government Insurance Network Employee Benefits Plan

PLAN CONTACT INFORMATION:

Administration through Marsh & McLennan Agency, LLC
Emma Lewis 847-463-7797
111 N Canal, Suite 550
Chicago, IL 60606
847-463-7797

SPD EFFECTIVE DATE:

January 1, 2026

PLAN YEAR:

The Plan Year ends each December 31st.

TYPE OF PLAN:

Welfare benefit plan

NAME AND ADDRESS OF THE CLAIMS PROCESSOR:

Function	Network Name	Claims Filing Information	Phone Number	URL
Medical PPO Network	Blue Cross Blue Shield of Illinois	BCBS P.O. Box 805107 Chicago, IL 60680-4112	(800) 541-2767	www.bcbsil.com
Medical HMO Network	Blue Cross Blue Shield of Illinois	BCBS 390 East Randolph St. Chicago, IL 60601-5009	(800) 892-2803	www.bcbsil.com
Dental PPO	Blue Cross Blue Shield PPO	BCBS P.O. Box 23059 Belleville, IL 62223-0059	(800) 541-2767	www.bcbsil.com
Vision	VSP	VSP PO Box 385018 Birmingham, AL 35238	(800) 877-7195	www.vsp.com
Life, AD&D, and Voluntary Life and AD&D	The Hartford	The Hartford Group Life Claims PO Box 14299 Lexington, KY 40512-4299	888-563-1124	www.thehartford.com
Accident	The Hartford	The Hartford Supplemental Insurance Benefit Department P.O. Box 99906 Grapevine, TX 76099	866-547-4205	https://myhealthhub.app/thehartford [myhealthhub.app]
Hospital Indemnity	The Hartford	The Hartford Supplemental Insurance Benefit Department P.O. Box 99906 Grapevine, TX 76099	866-547-4205	https://myhealthhub.app/thehartford [myhealthhub.app]

Critical Illness	The Hartford	The Hartford Supplemental Insurance Benefit Department P.O. Box 99906 Grapevine, TX 76099	866-547-4205	https://myhealthhub.app/thehartford [myhealthhub.app]
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SUMMARY PLAN DESCRIPTION

Blue Cross Blue Shield of Illinois, VSP, and The Hartford serve as the Plan's Claims Processors. Blue Cross Blue Shield of Illinois has developed a Medical and Dental Benefit Program booklet/certificate of coverage, and VSP and The Hartford have developed certificates of coverage ("Benefit Booklets") to provide you an overview of your Medical, Dental, Vision, and Basic and Voluntary Life and AD&D Benefits provided under the Plan. The Benefit Booklets together with this document serve as the Summary Plan Description (SPD) for the Plan and the Plan document. Please read the information in both portions of the SPD carefully so you will have a full understanding of your benefits. If you want more information or have any questions about your benefits under the Plan, please contact the Plan Administrator. Where a conflict exists between this document and the Benefit Booklets, the Benefit Booklets shall control. Certain participants under the Plan are also covered by a collective bargaining agreement between their collective bargaining group and a Member Employer. Where such a collective bargaining agreement applies, the agreement shall be determined to constitute a component of this Plan and its terms are incorporated into this document by reference.

ELIGIBILITY AND ENROLLMENT

WHO IS ELIGIBLE:

- **Employees:** A regularly assigned, full-time Employee of Member Employers that works or is credited with 30 or more hours of service per week. Notwithstanding the foregoing, Village of Westmont part-time employees who work 16 hours per week are eligible for the medical, dental, or vision coverage.

This definition specifically excludes independent contractors, temporary employees and part-time employees. However, the Plan may choose to extend coverage to any individual required to be offered coverage under the Affordable Care Act's Employer Shared Responsibility requirement, as long as such eligibility determinations are made in a nondiscriminatory manner.

- **Retirees:** All Qualified Retirees are eligible to participate in the Plan. A Qualified Retiree is an individual who:
 1. Worked for a Member Employer that participates in the Illinois Municipal Retirement Fund, and at the time of retirement from the Member Employer qualifies as a retiree under then-current Illinois Municipal Retirement Fund guidelines;
 2. Worked as a "fireman" for a Member Employer and qualifies for continued coverage under 215 ILCS 5/367f; or
 3. Worked as a "police officer" for a Member Employer and qualifies for continued coverage under 215 ILCS 5/367g.

If a Member Employer offers retiree coverage outside of the Qualified Retiree defined in 1, 2, and 3 above, requirements for retiree coverage will need to be provided to the plan administrator to be included in this document.

- **Dependents:**
 - **Dependent Children:** Child(ren) up to age 26 (30 for military veteran dependents, see paragraph immediately below) consisting of natural children, stepchildren, foster children, adopted children, and children placed for adoption.

Unmarried military veteran dependents are eligible under this Plan to their 30th birthday so long as they 1) reside in Illinois, 2) have served in the active or reserve components of the United States Armed Forces, including the National Guard, 3) have received a release or discharge other than a dishonorable discharge, and 4) have submitted a proof of service using a DD-214 (Member 4 or 6) form, otherwise known as a "Certificate of Release or Discharge from Active Duty." This form is issued by the federal government to all veterans. For more information as to how to obtain a copy of the DD-214, the veteran can call the Illinois Department of Veterans' Affairs at 1-800-437-9824 or the United States Department of Veterans' Affairs at 1-800-827-1000.

A child who is physically or mentally incapable of self-support upon attaining age 26 may be continued under the Plan, while remaining incapacitated and unmarried, subject to the covered Employee's own coverage continuing in effect. To continue a child under this provision, the Administrator must receive proof of incapacity within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

- **Spouse:** Spouse of the Employee. To be an Employee's spouse, a person must have met all requirements of a valid marriage in the state of Illinois or of the state or jurisdiction in which the marriage was entered into. A marriage between persons of the same sex, a civil union, or a substantially similar legal relationship other than common law marriage, legally entered into in another jurisdiction, shall also be recognized in Illinois as a civil union.

For avoidance of doubt, parents and stepparents are not eligible dependents under the Plan unless expressly provided in the applicable Certificate or SPD Booklet, required by law for a particular insured Benefit Program, or adopted by written Plan amendment.

ELIGIBLE TO ENROLL

Except where otherwise provided in a Benefit Booklet, all Employees shall be eligible on the first day of the month coinciding with or next following their date of hire.

Each Dependent of the Eligible Employee becomes eligible for Dependent coverage under the Plan on the later of the following:

4. The date the Employee is eligible; or
5. The date the individual becomes a Dependent of the Employee if on that date the Employee is covered.

EFFECTIVE DATE

Except where otherwise provided in a Benefit Booklet, all persons become covered, as they become eligible subject to the following:

1. All Employees shall be eligible on first day of the month coinciding with or next following the date of employment.
2. Each Dependent of the Eligible Employee becomes eligible for Dependent coverage under the Plan on the later of the following:
 - The date the Employee is eligible; or
 - The date the individual becomes a Dependent of the Employee if on that date the Employee is covered.

Coverage for a spouse will begin from the date of marriage. Coverage for a newborn birth child will begin from the date of birth. Coverage for a child placed under legal guardianship, an adopted child or a child placed for adoption with the Employee will begin from the date of Placement for Adoption. Coverage for a stepchild or foster child will begin from the date the child meets the definition of "Dependent."

With respect to a spouse, the spouse must be formally enrolled and appropriate coverage arranged within 31 days from date of marriage. With respect to a newborn birth child, the child must be formally enrolled and appropriate coverage arranged within 31 days from birth. With respect to a child placed under legal guardianship, an adopted child or child placed for adoption, the child must be formally enrolled and appropriate coverage arranged within 31 days from the date of Placement For Adoption. With respect to a stepchild or a foster child, the child must be formally enrolled and appropriate coverage arranged within 31 days from the date that the child meets the definition of “Dependent.”

ENROLLMENT

- **Open Enrollment Period:**

Each year, a period of time may be designated as an Open Enrollment period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that a Dependent who did not enroll during their initial eligibility period may enroll in a Plan. Coverage will become effective on the date specified by the Member Employer.

- **Late Enrollment Period:**

In the event that the Plan Administrator fails to offer an otherwise eligible individual coverage due to an administration error, an individual may apply for coverage or add dependents. Please contact the Plan Administrator for more information.

- **Special Enrollment**

The Plan permits a Special Enrollment period for an Employee (or a Dependent), who is eligible for coverage, but not enrolled, to enroll if the Employee (or Dependent) had other coverage and loses it, or if a person becomes a Dependent of the Employee through marriage, birth, adoption or Placement for Adoption. A person who enrolls during a Special Enrollment period is not treated as a late enrollee.

An individual may be eligible for Special Enrollment if the Employee, at the time coverage is declined, provides a statement, in writing, indicating the reason for declining coverage. To be eligible for Special Enrollment, the Employee must have declined coverage due to coverage under another plan. However, Special Enrollment will be available to Employees that decline coverage without having coverage under another plan and subsequently enroll in other coverage and lose that coverage. The Employee must have had an opportunity for Late Enrollment, Open Enrollment or Special Enrollment under this Plan but again chose not to enroll. Special Enrollment is also available to an Employee or Dependent who becomes eligible for a premium assistance subsidy under Medicaid or a state Children’s Health Insurance (CHIP) program with respect to this Plan.

If the Employee declined coverage because the other coverage was COBRA coverage, then the COBRA coverage must be exhausted before Special Enrollment will be available. If the other coverage is not COBRA coverage, then to be eligible for Special Enrollment, the other coverage must be lost due to a loss of eligibility, or employer contributions must have ended. Loss of eligibility includes a loss of coverage due to:

- divorce;
- legal separation;
- death;

- termination of employment, or reduction in hours of employment;
- relocating outside of an HMO's service area (only if there is no access to other coverage through the HMO);
- a plan no longer offering benefits to a class of similarly situated individuals even if the plan continues to provide coverage to other individuals;
- the Employee or Dependent is covered under a Medicaid plan or under a state CHIP program, and coverage of the employee or dependent under such a plan/program is terminated as a result of loss of eligibility for such coverage.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if their Dependent has a Special Enrollment right because the Dependent lost other health coverage.

Under Special Enrollment, the Employee must request enrollment, in writing within 31 days after the exhaustion of COBRA, or termination of the other coverage (other than Medicaid or Children's Health Insurance, see below), or the date of the marriage, birth, adoption or placement for adoption. If eligible, enrollment in the Plan, in cases of marriage, birth or adoption/Placement for Adoption, will be effective as of the date of the event; otherwise, coverage will be available no later than the first day of the first month beginning after the completed request for enrollment is received.

Under Special Enrollment, the Employee must request enrollment, in writing within 60 days after the termination of Medicaid or Children's Health Insurance (CHIP) coverage, or when eligible for a premium assistance subsidy under Medicaid or a state CHIP program. If eligible, enrollment in the Plan will be effective no later than the first day of the first month beginning after the completed request for enrollment is received.

TERMINATION OF COVERAGE:

- **Employee:** Except where otherwise provided in a Benefit Booklet, the coverage of any Employee covered under this Plan shall terminate on the earliest of the following :
 - The last day of the calendar month in which the person ceases to meet the eligibility requirements under the Plan;
 - The date of termination of the Plan.
- **Dependent:** Except where otherwise provided in a Benefit Booklet, the coverage of any Dependent covered under this Plan shall terminate on the earliest of the following:
 - The date of the event on which such individual ceases to be an eligible Dependent under the Plan (except that Medical coverage for a Dependent child who attains age 26 shall continue through the end of the month); or
 - The date the Employee's coverage terminates under the Plan.

NETWORK BENEFITS

Your Plan contains enhanced benefits through network providers. The name of the organization associated with these network providers is indicated on the front of Your ID card, along with instructions regarding where to file medical claims. Benefits are generally paid at a higher level when using network Hospitals and network Physicians than when using non-network providers. For HMO coverage options, there may be no benefits payable for services received at non-network providers. Please refer to the appropriate HMO, PPO Plan or HDHP Plan Schedule of Covered Expenses for benefits payable according to type of provider used. For on-line inquiry to locate a network provider near You, or to verify that a provider is in the PPO or HMO network, visit the website listed on Your ID card. For direct assistance in locating network providers, call the "Provider Referral Number" listed on Your ID card.

A Covered Person has a free choice of any provider for medical care. At any time, the Covered Person may choose any qualified provider with the understanding that different benefits may apply according to the provisions of the Plan.

PROCEDURES FOR FILING CLAIMS

Remember to Pre-Certify (where required) by calling the toll-free number shown on Your ID card if required by Your Plan.

KEY POINTS TO REMEMBER

The claims filing address You must use for filing all medical claims is shown on Your ID card.

1. Each bill should be itemized as to services, show payment status, and include the name of the patient, the Employee's social security number or unique identification number ("UID"), and the name and/or group number of the Member Employer.
2. It is Your responsibility to see that all bills are submitted as indicated above. Proper payment cannot be made without the proper bills.
3. All charges, and corresponding requested documentation, must be submitted within the time frame specified in the Schedule of Covered Expenses and Provisions. Failure to do so will result in the denial of the charges.
4. From time to time, additional information may be requested to process Your claim. Any additional information, i.e. other insurance payments or information, completed claim forms or subrogation forms, accident details, police reports, etc. must be submitted by You or Your provider(s) when requested within the time frame specified in the Schedule of Covered Expenses and Provisions. Your failure to do so will result in the denial of the claim.
5. Only clean claims will be adjudicated by the Plan. A clean claim is one that is complete and accurate, does not require further information for processing from the provider, patient, or any other person or entity, and leaves no issues regarding the Plan's responsibility for payment.

MISCELLANEOUS CLAIMS FILING CONSIDERATIONS

It is necessary to keep separate records of Your expenses with respect to each of Your Dependents and Yourself. The following items are important and should be carefully kept to be submitted with Your claim:

1. All Physician's bills should show the following:
 - a. Name of patient and adequate membership information
 - b. Dates and charges for services, and payment status of each
 - c. Types of service rendered and procedure codes
 - d. Diagnosis information
2. Prescription drug expenses should show the following:
 - a. Name of patient and adequate membership information
 - b. Prescription number and name of drug
 - c. Cost of the drug and date of purchase. Cash register receipts and canceled checks cannot be accepted for payment
 - d. Generic Drugs should be indicated on the drug bill
3. Bills for all other covered medical charges, such as for ambulance service, durable medical equipment, etc. should show the following:
 - a. Name of patient and adequate membership information
 - b. Date of service

- c. Charge and description of each service/item
- d. Diagnosis information

Always retain a copy of the bill for Your records. Claims must be filed within one year of the date charges for the services were incurred.

THIS PLAN AND MEDICARE

1. Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.
2. When an Employee becomes entitled to Medicare coverage and is still actively at work, the Employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
3. When a Dependent becomes entitled to Medicare coverage and the Employee is still actively at work, the Dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
4. If the Employee is still actively at work, and the Employee and/or Dependent are also enrolled in Medicare, this Plan shall pay as the primary plan. Medicare will pay as secondary plan.
5. If the Employee and/or Dependent elect to discontinue health coverage and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.

This section is subject to the terms of the Medicare laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

GENERAL PROVISIONS

Claims procedures are generally described in the applicable Benefit Booklet. Except where noted in the applicable Benefit Booklet, a claim for benefits must be filed no later than one year following the date the service is provided or the claim accrues, otherwise it will be denied as untimely.

ADMINISTRATION OF THE PLAN

The Plan is administered through the Office of the Administrator. The Administrator has delegated claims processing authority to an independent Claims Processor experienced in claims processing (except with respect to eligibility determinations). Fiscal records are maintained for a Plan Year ending as of the date specified under the Key Information section at the beginning of this document.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Administrator at the address specified in the Key Information section at the beginning of this document.

CLAIMS PROCEDURES

PROCEDURES REGARDING ELIGIBILITY

These procedures apply to claims for eligibility for coverage or enrollment in the Plan.

Filing a Claim

If you believe that you or your dependent is eligible for coverage under the Plan, you may file a claim in writing with the Plan Administrator or the Plan's Administrators delegate.

Initial Claim Decision

When an eligibility or enrollment claim is received, the Plan Administrator must notify you of its benefit determination within 90 days of the receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. You will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.

The Plan Administrator will send you a written notice of an adverse benefit determination. A denial of a claim will include:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan's appeal procedures and the time limits applicable to the appeal process.

Appealing an Eligibility or Enrollment Claim Denial

If you (or your duly authorized representative) believe that a denial is incorrect, you may request a full review by the Plan Administrator, or its delegate, within 60 days after your receipt of the denial of your claim. In connection with your appeal, you or your representative may submit written comments, documents, records and other information relating to the claim. You also have the right to request copies of all relevant documents (free of charge).

The Plan Administrator will furnish you with a written decision providing the final determination of the appeal. The Plan Administrator's decision on appeal usually will be made within 60 days after receiving your appeal, unless special circumstances require an extension of an additional 60 days. If the period is extended, the Plan Administrator will notify you in writing of the extension within 60 days of receiving your appeal. The Plan Administrator's decision on review will be final and binding on you, your dependents and any other interested party. Your appeal notice will include:

- The specific reason or reasons for the appeal decision;
- Reference to the specific Plan provisions on which the determination is based; and
- A statement that you have the right to request access to and copies of all relevant Plan documents free of charge.

PROCEDURES REGARDING ADVERSE BENEFIT DETERMINATIONS

An explanation of benefits or other written or electronic notification will be provided by the Plan Administrator showing the calculation of the total amount payable for the claim, charges not payable, and the reason. If the claim is denied or reduced in whole or in part, it is considered an "Adverse Benefit Determination." An Adverse Benefit Determination also includes a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time of the rescission. An Adverse Benefit Determination is subject to the provisions detailed below. Claims must be filed within one year of the date charges for the services were incurred.

The Plan Administrator will notify the claimant of an Adverse Benefit Determination within 30 days after receipt of the claim. However, in certain cases an extension of up to 15 days may be utilized if the Plan Administrator determines that the extension is necessary due to matters beyond the control of the Plan and the claimant is notified prior to the expiration of the initial 30 day period of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If such an extension is necessary due to a failure of claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be given at least 45 days within which to provide the specified information.

A notice of Adverse Benefit Determination will include the following:

- Sufficient information to identify the claim involved, including the date(s) of service, health care provider, and claim amount.
- The specific reason or reasons for the Adverse Benefit Determination, as well as the Plan's standard that was used in denying the claim, if applicable, and including identifying denial

codes and providing their meaning.

- Reference to specific Plan provisions on which the Adverse Benefit Determination is based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's first level appeal procedures and the time limits applicable to such procedures, including information on how to initiate an appeal, the contact information for the Illinois Office of Consumer Health Insurance (877-527-9431) to assist individuals with the first level claim and appeal process and second level (external) appeal process.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the notice of Adverse Benefit Determination; or the notice will contain a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either 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 set forth in the notice of Adverse Benefit Determination, or the notice will contain a statement that such explanation will be provided free of charge upon request.

First Level Appeals Procedures

If You receive an Adverse Benefit Determination, You or Your authorized representative may appeal the determination by filing a written application with the Plan Administrator. In appealing an Adverse Benefit Determination, the Plan Administrator will provide You or Your authorized representative:

- The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
- Upon request and free of charge, reasonable access to, and copies of, all documents, records, the claim file, and other information relevant to the claim.
- A full and fair review that takes into account all comments, documents, records, and other information submitted by You relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. You must also be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan Administrator, as well as any new or additional rationale relied upon by the Plan Administrator in reaching its determination on appeal, that differs from that which the Plan Administrator relied on in its Adverse Benefit Determination. Such evidence and/or rationale must be provided as soon as possible and sufficiently in advance of the date on which the Plan Administrator's determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

- A full and fair review that does not afford deference to the initial benefit determination and is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
- In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, that the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that the health care professional consulted shall neither be an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
- Upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

A first level appeal must be filed within 180 days after the Adverse Benefit Determination is received. The Plan Administrator will notify You or Your authorized representative of its determination within 60 days after receipt of an appeal.

The Plan Administrator's determination:

- Will contain sufficient information to identify the claim involved, including the date(s) of service, health care provider, claim amount, denial codes and their meaning, as well as the Plan's standard used in denying the claim.
- Will be in writing, setting forth specific reasons for the decision and reference to the specific Plan provisions upon which the determination is based.
- Will contain a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
- Will contain a description of the Plan's second level (external) review process, including information on how to initiate a second level appeal, and the contact information for the Illinois Office of Consumer Health Insurance (877-527-9431) to assist individuals with the second level review process.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the determination; or the determination will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit 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.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either 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 set forth in the determination or the determination will contain a statement that such explanation will be provided free of charge upon request.

If the Plan does not strictly adhere to all the requirements of the first level claims and appeals process with respect to a claim, You are deemed to have exhausted the first level claims and appeals process. Accordingly, upon such a failure, You may initiate a second level (external) review and pursue any available remedies under applicable law.

Second Level (External) Appeals Procedure

If the Plan denies Your first level appeal, in whole or in part, such denial is called a Final Internal Adverse Benefit Determination. You or Your authorized representative may file a second level (external) appeal of the Final Internal Adverse Benefit Determination by filing a written application with the Illinois Department of Insurance. (However, You may not file a second level appeal of the Final Internal Adverse Benefit Determination to the extent that determination related to a failure to meet the requirements for eligibility under the terms of the Plan.)

To request a second level appeal, or for further information, contact the Director of the Illinois Department of Insurance at:

Illinois Department of Insurance
Office of Consumer Health Insurance
EXTERNAL REVIEW REQUEST
320 W. Washington Street
Springfield, IL 62767
(877) 850-4740 (toll-free phone number)
(217) 557-8495 (fax)
DOI.externalreview@illinois.gov

For a copy of the second level appeal claims procedures, contact the Plan Administrator.

Reversal of the Second Appeal decision.

Upon receipt of a notice of a final external review decision reversing the Final Internal Adverse Benefit Determination, the Plan must immediately pay the claim.

For questions about Your appeal rights or for assistance, You can contact the Illinois Office of Consumer Health Insurance at 877-527-9431.

EXHAUSTION REQUIRED

Except where provided in the applicable Benefit Booklet, all claims procedures must be exhausted before you may file a civil action to receive benefits under the Plan. Any such civil action must be brought no later than one year following the date you receive your final adverse benefit determination.

Any such cause of action must be brought in Will County courts, and Illinois law shall govern.

ASSIGNMENT OF BENEFITS

The Plan will use its best efforts to recognize assignments of benefits from providers of services but is not bound by such assignments. Notwithstanding the foregoing, the Plan will not recognize

any assignment of a Covered Person's right to bring a cause of action or otherwise initiate a legal proceeding arising from an adverse benefit determination. When payment is made directly to the Covered Person (with or without an assignment), it is solely the responsibility of the Covered Person to reimburse the provider.

CLAIM AUDIT

Once a written claim for benefits is received, the Plan Administrator, at its discretion, may elect to have such claim reviewed or audited for accuracy, Reasonableness and/or the Usual and Customary nature of charges as part of the adjudication process. This process may include, but not be limited to, identifying charges for items/services that may not be covered or may not have been delivered, duplicate charges and charges beyond the Reasonable and/or Usual and Customary guidelines as determined by the Plan Administrator.

COMPLIANCE

The Plan shall comply with all applicable federally mandated benefit laws and regulations pertaining to employee benefit plans. The intent of the Plan is to assure full compliance with all appropriate federal laws, rules and regulations and any act or omission through negligence or otherwise which results in any such violation, shall be construed as unintentional. The Claims Processor shall be fully discharged from liability under this Plan.

CONTACT INFORMATION FOR THE PLAN ADMINISTRATOR, NAMED FIDUCIARY, AND AGENT FOR SERVICE OF LEGAL PROCESS

Same as Administrator.

CONTRIBUTIONS

The benefits provided under the terms of this Plan are purchased through Member Employer contributions (which may be used to pay premiums for an insurance policy). At the discretion of the Member Employer, Employees may be required to contribute on a payroll deduction basis.

FUNDING

This medical and dental benefits under the Plan are self-funded. The vision and life insurance benefits under the Plan are fully-insured.

LIENS

To the full extent permitted by law, all rights and benefits accruing under this Plan shall be exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Employee.

This Plan is not a substitute for and does not affect any requirement for coverage by Workers' Compensation Insurance.

NO WAIVER

A failure to enforce any provision of this Plan shall not affect any right thereafter to enforce any such provision, nor shall such failure affect any right to enforce any other provision of this Plan.

PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract between the Administrator/Member Employers and any Employee or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the

right to be retained in the service of any Member Employer or to interfere with the right of a Member Employer to discharge any Employee at any time.

PLAN AMENDMENT, MODIFICATION OR TERMINATION

The Administrator reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time and such amendment, modification, revocation or termination of the Plan shall be made by a written Plan endorsement signed by an authorized representative of the Administrator. Any such changes to the Plan, which affect participants, will be communicated to such participants by the Plan Administrator. Upon termination of the Plan, the rights of participants to benefits are limited to claims incurred and due up to the date of termination.

PROHIBITION ON RESCISSION

The Plan cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to an individual before coverage may be rescinded.

NON-DISCRIMINATION

In regard to the offering of coverage, the Plan will not discriminate against any individual on the basis of health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. No otherwise eligible individual will be refused the opportunity to enroll in the Plan due to participation in any particular activity, regardless of its hazardous nature. The Plan will not discriminate against similarly situated individuals in regard to eligibility or benefits (however, this does not limit the Plan's ability to treat participants classifiable through non-health related criteria as different groups in different ways.) The Plan will not knowingly discriminate against any individual on the basis of health factors. However, the Plan may impose coverage limits or exclusions on all similarly situated individuals which may have an effect on only some individuals.

REIMBURSEMENT AND SUBROGATION PROVISIONS

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an illness, injury, or disability is caused in whole or in part by, or results from the acts or omissions of, a Covered Person or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

However, such payment of benefits by the Plan shall be made only if the Covered Person first provides a reimbursement agreement in writing. Notwithstanding the foregoing, payment of any claim in the absence of a signed reimbursement agreement shall not invalidate the obligation of the Covered Person to otherwise reimburse the Plan.

The Covered Person (including his attorney, and/or legal guardian of a covered minor or incapacitated individual) agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the Covered Person agrees the Plan shall have an

equitable lien on any funds received by the Covered Person and/or his attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Covered Person settles, recovers, or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or who may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is only one, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness, Injury or disability to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may, at its discretion, in its own name or in the name of the Covered Person commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person fails to file a claim or pursue damages against:

- a) the responsible party, its insurer, or any other source on behalf of that party;
- b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c) any policy of insurance from any insurance company or guarantor of a third party;
- d) worker's compensation or other liability insurance company; or
- e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

The Plan shall have the specific right of first recovery (“reimbursement”), and as such, shall be entitled to recover 100% of the benefits paid, without deduction for attorneys’ fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan’s equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person’s recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts’ fees, attorneys’ fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan’s recovery without the prior, expressed written consent of the Plan.

The Plan’s right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan’s recovery will not be applicable to the Plan and will not reduce the Plan’s reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person, or filing of bankruptcy by the Covered Person(s), will not affect the Plan’s equitable lien, the funds over which the Plan has a lien, or the Plan’s right to subrogation and reimbursement.

WRONGFUL DEATH

In the event that the Covered Person dies as a result of his injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan’s subrogation and reimbursement rights shall still apply.

OBLIGATIONS

It is the Covered Person’s obligation at all times, both prior to and after payment of medical benefits by the Plan:

- a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan’s rights;
- b) to provide the Plan with pertinent information regarding the Illness, Injury, or

disability, including accident reports, settlement information and any other requested additional information;

- c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights, including providing to the Plan an executed reimbursement agreement;
- d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.

If the Covered Person and/or his attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's cooperation or adherence to these terms.

OFFSET

Failure by the Covered Person and/or his attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits, and any funds, or payments due under this Plan on behalf of the Covered Person may be withheld until the Covered Person satisfies his obligation.

MINOR STATUS

In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine acceptability of any applicant for participation in the Plan.

In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

RIGHTS OF RECOVERY

Whenever payments have been made by the Plan which are in excess of the maximum amount allowed under the Plan or are otherwise not covered under any provision of the Plan, the Claims Processor or Plan Administrator shall have the right to recover such payments from among one or more of the following: any persons to, for or with respect to whom such payments were made; any providers of service; any insurance companies or any other organizations. Current benefit payments may be reduced to satisfy outstanding reimbursements.

SEVERABILITY

Should any provision of this Summary Plan Description be declared invalid or illegal for any reason, such invalidity or illegality shall not affect the remaining portions of the Summary Plan Description. Any remaining portions shall remain in full force and effect, as if this Summary Plan Description did not contain the invalid or illegal provision.

SUBMISSION OF CLAIM

All charges, and corresponding requested documentation, must be submitted by the date specified in the Schedule of Covered Expenses and Provisions. Failure to do so will result in the denial of the charges.

TYPE OF ADMINISTRATION

The Plan is self-administered by the Plan Administrator. The Plan Administrator has hired a Claims Processor to process claims and provide consulting services and ministerial functions.

COORDINATION OF BENEFITS (COB)

The Coordination of Benefits provision is intended to prevent payments of benefits that exceed expenses. It applies when any other plan or plans also cover the person covered by this Plan. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always 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. Only the amount paid by the Plan will be charged against the Plan maximums. See Schedule of Covered Expenses and Provisions to determine the type of Coordination of Benefits this Plan provides.

To coordinate benefits, it is necessary to determine in what order the benefits of various Plans are payable. This is determined as follows:

1. If a plan does not have a provision for the coordination of benefits, its benefits are payable before this Plan.
2. If a plan covers a person other than as a Dependent, its benefits are payable before this Plan. This includes Medicare covering a person other than as a Dependent (e.g. a retired Employee) and any Medicare Supplement Plan. However, in all instances, federal regulations regarding Medicare as a secondary payer will apply.
3. If a plan covers an active Employee, its benefits are payable before this Plan. This order of determination does not supersede No. 2 above.
4. If an individual is covered as a Dependent under 2 separate plans, the benefits are payable first under the Employee's plan having the earliest birthday in a Calendar Year. However, if the Dependent is a child whose parents are separated or divorced, the "birthday rule" does not apply. The following order to determination will apply:

If the parent with custody has not remarried:

- a) The plan of the parent with custody is primary.
- b) The plan of the parent without custody is secondary.

If the parent with custody has remarried:

- a) The plan of the parent with custody is primary.
- b) The plan of the stepparent with custody is secondary.
- c) The plan of the parent without custody is tertiary (third).

There may be a court decree that makes one parent financially responsible for the health care expenses incurred by the child. If a plan covers the child as a Dependent of that parent, its benefits are payable before those of a plan that covers the child as a Dependent of the parent without financial responsibility.

5. If a plan covers an individual who is also allowed to be covered by this Plan pursuant to COBRA continuation coverage, its benefits are payable before this Plan.
6. If items 1, 2, 3, 4 or 5 do not apply, the benefits of a plan that has covered the person for the longest period of time will be payable before those of the other plan.

To the extent that the Plan would be secondary to Medicare, if a Covered Person is eligible for Medicare Part A and/or Part B and does not elect to enroll in such Medicare coverage, then Plan benefits will be coordinated based on an estimate of what Medicare would have paid, regardless of whether benefits are actually received from Medicare.

Any other "plan" means and includes, but is not necessarily limited to the following: any policy, contract or other arrangement for group insurance benefits, including any Hospital or medical service organization plan or other service or prepayment plan arranged through any employer, union, trustee, Employee benefit association, government agency or professional association; or any homeowner's policy or other policy providing liability coverage; or any coverage for students sponsored by or provided through a school or other educational institution; or any coverage

provided by a licensed Health Maintenance Organization (HMO); or any benefits payable under Medicare (to the extent permitted by law); or any government program or any coverage provided by statute.

The term “plan” shall also mean any mandatory “no-fault” automobile insurance coverage providing benefits under a medical expense reimbursement provision for Hospital, medical, or other health care services and treatment because of accidental bodily Injuries arising out of a motor vehicle accident; and any other payment received under any automobile policy.

To administer this provision, the Administrator has the right to:

1. Release or obtain data needed to determine the benefits payable under this provision
2. Recover any sum paid above the amount that is required by this provision and
3. Repay any party for a payment made by the party, when the Administrator should have made the payment.

COMPLIANCE REGULATIONS

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., Your Physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain pre-certification. For information on pre-certification, contact Your Plan Administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) MASTECTOMY BENEFITS NOTICE

Federal law requires this Plan to provide the following benefits for elective breast reconstruction in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications in all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient. Such coverage is subject to all other Plan terms and limitations.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you are eligible for health coverage under the Plan, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. An updated list of states with premium assistance programs, along with program contact information, is available at <http://www.dol.gov/ebsa/chipmodelnotice.doc>.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse/permanent partner) because of other health plan coverage, you may in the future be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage, provided that you request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your eligible dependents at that time. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator.

SOURCE OF INJURY RESTRICTIONS

The Plan will not limit coverage for Injuries or Illnesses resulting from 1) domestic violence, or 2) self-inflicted injury or attempted suicide. Further, the Plan will not limit coverage for Injuries or Illnesses resulting from participation in any activity if such Illness or Injury is as a result of a physical or mental condition.

FAMILY MEDICAL LEAVE ACT (FMLA)

The following applies to companies with 50 or more employees

If the Covered Person is entitled to, and elects to take, a family or medical leave solely under the terms of the Family and Medical Leave Act of 1993 (FMLA), the Covered Person and his covered Dependents shall continue to be covered under this Plan while the Covered Person is absent from work on an FMLA leave as if there were no interruption of active employment. Provided the applicable premium is paid, such coverage will continue until the earlier of the expiration of such leave or the date notice is given to the Administrator that the Covered Person does not intend to return to work at the end of the FMLA leave.

The Covered Person may choose not to retain health coverage during the FMLA leave. If he returns to active working status on or before the expiration of the leave, he is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. (Coverage will be reinstated without any additional qualification requirements imposed by this Plan. This Plan's provisions with respect to pre-existing conditions, Deductibles and percentage of payments will apply on the same basis as they did prior to the FMLA leave.)

MILITARY LEAVES

If You are absent from work due to military service, You may elect to continue coverage under the Plan (including coverage for enrolled Dependents) for up to 24 months from the first day of absence (or, if earlier, until the day after the date You are required to apply for or return to active employment with a Member Employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)). Your contributions for continued coverage will be the same as for a COBRA beneficiary, except that, if You are absent for 30 days or less, Your contribution will be the same as for similarly situated active participants in the Plan.

Whether or not You continue coverage during military service, You may reinstate coverage under the Plan on Your return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Plan, except to the extent that You had not fully completed any required waiting period prior to the start of military service.

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You when You would otherwise lose Your group health coverage. It can also become available to other members of Your family who are covered under the Plan when they would otherwise lose their group health coverage. Although not required by COBRA, the Plan will extend continuation coverage that is similar to COBRA to civil union partners and children of civil union partners.

For additional information about Your rights and obligations under the Plan and under federal law, You should review this Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, Your spouse, and Your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from Your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that

bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer (if the Plan provides retiree coverage), or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE WRITTEN NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), You must notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice in writing to the Plan Administrator at the address indicated in the Key Information section at the beginning of this document. IF YOU, YOUR SPOUSE OR YOUR DEPENDENT FAIL TO PROVIDE TIMELY WRITTEN NOTICE TO THE PLAN ADMINISTRATOR AFTER A DIVORCE, LEGAL SEPARATION OR LOSS OF DEPENDENT CHILD ELIGIBILITY, THE RIGHT TO ELECT TO PURCHASE COBRA CONTINUATION COVERAGE IS WAIVED.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), Your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

If the Plan has retiree coverage, and if the employer from whose employment the covered retiree retired files a Chapter 11 bankruptcy reorganization, and the covered retiree loses coverage within one year before or after the bankruptcy filing, a qualifying event has occurred. That is, COBRA coverage could continue until the death of the retiree, or until the death of a covered surviving spouse of a deceased retiree, or for 36 months from the retiree's death in the case of a spouse or dependent.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation

coverage generally lasts for only up to a total of 18 months. There are 2 ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of continuation coverage. A copy of the determination of disability by the Social Security Administration must be sent to the Plan Administrator at the address indicated in the Key Information section at the beginning of this document within 60 days after the date the determination is issued and before the end of the 18-month maximum coverage period that applies to the qualifying event. Any individual who is either the employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the employee or qualified beneficiary, may send the written notice to the Plan Administrator. Such individual(s) must further notify the Plan Administrator in writing within 30 days after a determination has been made that the person is no longer disabled. The Plan may require the payment of an amount that is up to 150 percent of the applicable premium for the period of extended coverage as long as the disabled individual is included in the extended coverage period.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the date of the first qualifying event, if notice of the second qualifying event is properly sent in writing to the Plan Administrator at the address indicated in the Key Information section at the beginning of this document. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated. This extension may also be available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, You must make sure that the Plan Administrator is sent written notice of the second qualifying event within 60 days of the second qualifying event.

ELECTION OF COBRA CONTINUATION COVERAGE

There is no requirement to show evidence of good health in order to choose COBRA coverage. However, the COBRA participant will have to pay all of the cost to the Plan for COBRA coverage, and may be charged an additional 2% administrative fee. A 50% administrative fee may be charged if coverage is extended due to a disability and the disabled individual is in the extended coverage period.

Any individual eligible for COBRA coverage has 60 days from the later of the date of the COBRA notification letter or the date coverage is lost to elect such coverage. Also, an eligible individual electing COBRA coverage has 45 days from the date of election to pay the initial premium. THEREAFTER, PAYMENT IS DUE ON THE FIRST DAY OF EACH MONTH WITH A 30-DAY GRACE PERIOD.

If a qualifying event occurs, the Plan Administrator will notify those eligible individuals of the procedure for electing COBRA coverage and the cost of such coverage.

In considering whether to elect continuation coverage, You should take into account that a failure to continue Your group health coverage will affect Your future rights under federal law. First, You can lose the right to avoid having pre-existing condition exclusions applied to You by other group health plans if You have more than a 63-day gap in health coverage, and election of continuation coverage may help You not have such a gap. Second, You will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if You do not get continuation coverage for the maximum time available to You. Finally, You should take into account that You have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which You are otherwise eligible (such as a plan sponsored by Your spouse's employer) within 30 days after Your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if You get continuation coverage for the maximum time available to You.

IF THE EMPLOYEE, SPOUSE OR DEPENDENT FAILS TO EXERCISE THE ELECTION WITHIN THE 60-DAY PERIOD, THE RIGHT TO ELECT TO PURCHASE COBRA COVERAGE IS WAIVED. IF ANY PREMIUM PAYMENT IS NOT MADE WITHIN THE TIME FRAMES SPECIFIED ABOVE, COBRA COVERAGE WILL BE FORFEITED.

If coverage under the Plan is modified for active Employees, coverage shall also be modified in the same manner for COBRA coverage participants. COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

TERMINATION OF COBRA CONTINUATION COVERAGE

Certain events can cut short the 18, 29 or 36 month continuation periods. They are:

1. The Administrator's termination of the Plan.
2. The COBRA participant first becomes, after the date of election, entitled to Medicare benefits.
3. The COBRA participant first becomes, after the date of election, covered under another group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such participant.
4. The COBRA participant fails to pay the premium in a timely manner.

In no event shall coverage extend beyond the applicable maximum period.

TRADE ACT OF 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the applicable tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If You have questions about these new tax provisions, You may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. Information about the Trade Act is also available at www.doleta.gov/tradeact.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified under Plan Contact Information in the Key Information section at the beginning of this document. For more information about Your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws

affecting group health plans, contact the Illinois Department of Insurance at www.idoi.illinois.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

PLAN CONTACT INFORMATION

If there are any questions regarding COBRA Continuation Coverage under the Plan, please contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document.

NO SUPPRISES ACT

The No Surprises Act of the Consolidated Appropriations Act, 2021 (the "CAA"), protects you from "surprise billing" or "balance billing" when you get emergency care at an out-of-network hospital or when you receive care from an out-of-network provider who is working at a hospital or ambulatory surgical center in your health plan's network.

A "balance bill" is a bill charged to you by an out-of-network provider or facility to make up the difference between what your health plan pays and the provider charges for the items or services rendered. "Surprise billing" is an unexpected balance bill you receive from a provider or facility. This can happen when you receive care from a facility that is in-network but one of the providers at the facility is out-of-network.

Under the No Surprises Act, you are protected from balance billing for emergency services provided by out-of-network providers, including services you may get after you are in stable condition (unless you give written consent and give up your protections against balanced billing for post-stabilization services). You are also protected from surprise bills from services you receive from out-of-network providers while at an in-network hospital or ambulatory surgery center, such as services for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistance surgeon, hospitalist, or intensivist services. The most the providers can bill you is your in-network cost-sharing amount, and they can't ask you to give up your protections from being balance billed. If you receive other services at in-network facilities, out-of-network providers cannot balance bill you unless you provide written consent. Written consent can never be required. Further, you can always choose to get care at an in-network facility or from an in-network provider instead of getting care from an out-of-network provider or facility.

The Plan covers emergency services without requiring you to get approval for such services in advance, which is known as prior authorization. Further, the Plan covers emergency services even if those services are provided by providers who are outside the plan's network. Your required cost sharing (co-pays, coinsurance, or deductibles) for emergency care received by an out-of-network provider or facility will be the same as what you pay a provider or facility in the Plan's network. That amount will be included in your explanation of benefits. Finally, the amount of any cost-

sharing you pay for emergency services or out-of-network services will count towards your applicable maximum annual deductible and out-of-pocket limits under the Plan. Contact the Plan Administrator for more information.