

DMH HEALTH PLAN
Summary Plan Description

Effective January 1, 2010

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A WORD ABOUT THE BOOKLET

This booklet is called a “summary plan description,” or SPD. It is designed to summarize a complex plan document and not to alter that document in any way. You should not rely on this information other than as a general summary of the DMH Health Plan’s (the “Plan”) features. In the event of any difference between the terms of this SPD and the Plan document, the terms of the Plan document will control. You may review the Plan document by requesting a copy from your Human Resources Department.

Wherever possible, the booklet avoids legal or insurance terminology. Occasionally, the booklet does use terms such as “Medically Necessary,” “Experimental,” or “Pre-Existing Condition” that have precise and important meanings. When such terms are used, they are capitalized and they are carefully and precisely defined in the Plan document.

The effective date of this SPD is January 1, 2010 and this booklet replaces all previous summaries or explanatory materials that you have received. This booklet will remain in effect until it is completely replaced by Decatur Memorial Hospital with a booklet with a later effective date. This booklet may be updated and modified through communications from Decatur Memorial Hospital. To determine the proper benefits for any given period, it is important that you consult the SPD that was in effect at that time.

If you have questions about the Plan that this booklet does not answer, please contact:

Human Resources Department
Decatur Memorial Hospital
2300 North Edward Street
Decatur, Illinois 62526
Phone: (217) 876-6111

AN OVERVIEW OF OUR PLAN

The DMH Health Plan is a self-insured medical benefits plan, meaning that benefits are paid out of the general assets of Decatur Memorial Hospital (DMH), rather than guaranteed by an outside insurance company.

The PPO600 Plan, Wrap Around Plan, and HDP Premier Plan options were eliminated for 2010. For 2010, you can select from two (2) benefit options – the PPO Plan option and the HDP Select Plan option. These options cover similar services and procedures, but they provide different levels of coverage (for example, higher or lower deductibles) and premiums vary accordingly. Each year, DMH determines the amount it will contribute toward your coverage and the balance is payable by the employee.

Two options under the Plan use a preferred provider network. The preferred provider network is Consociate PPO Network and DMH is part of this network. Network providers agree to contracted rates for services. Therefore, the Plan pays a higher benefit if you use a network provider. You are not required to receive services from a network provider. You may see any health care provider you choose. If your health care provider is not a network provider, eligible expenses paid by the Plan are paid on a reduced basis. To find a medical/surgical DMH network or Consociate PPO provider, please contact Consociate Group at 217-423-7788 or visit www.consociategroup.com.

You should be familiar with several important restrictions on benefits under the Plan, each of which is explained more fully later in this booklet.

- The Plan provides no benefits for services or supplies that the claims administrator determines are not “medically necessary.”
- The Plan is designed to encourage use of DMH and other network providers, when appropriate. If you voluntarily use non-network providers (other than for emergency treatment, of course), you will incur higher out-of-pocket expenses.
- You may be required to seek pre-certification or other approval to ensure that services or supplies for non-emergency treatment are covered by the Plan.

As Plan Administrator, the Plan Administrative Committee at DMH has full discretion and power to make (or to delegate the authority to make) all determinations under the Plan, including questions of eligibility for benefits and questions of Plan interpretation, including the making of factual determinations. The Plan Administrator shall have the discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

DMH also reserves the right to modify or amend or terminate the Plan by action of its board of directors or other entity to which DMH has assigned this power.

ELIGIBILITY

Who is eligible to participate?

You are eligible to participate if you are an employee of DMH and you are regularly scheduled to work at least 17 hours per week, and have been employed by DMH for at least 90 days. You are also eligible to participate if you are a Bradley University anesthesiology student serving a residency at DMH. Employees who are not regularly scheduled to work – such as those that DMH classifies as “per diem” employees – are not eligible. Independent contractors, consultants, temporary, seasonal, and leased employees are not eligible to participate. Collectively bargained employees are not eligible to participate unless their union agreement provides for participation in the Plan.

If your employment status changes and you become eligible to participate in the Plan after being ineligible (*e.g.*, you initially work part-time and change your regular schedule to work at least 17 hours per week), you are eligible effective as of the first day of the month following 90 days of employment as an eligible Employee.

When does my coverage begin?

You will be eligible to participate once you have been employed for at least 90 days. Coverage will begin on the first day of the month following, or corresponding with the completion of, 90 days of employment. If your employment status changes and you become eligible to participate in the Plan after being ineligible, coverage will begin on the first day of the month following 90 days of employment as an eligible Employee.

Which dependents are eligible to participate if I am participating?

If you participate in the Plan, your spouse may also participate.

If you participate, eligibility will also extend to your unmarried natural children, stepchildren, legally adopted children, children placed for adoption, and children for whom you are legal guardian. Your children will be eligible for coverage as long as they are primarily dependent upon you for support and maintenance up to age 19. Eligibility will extend up to age 23 for children who are full-time students at an accredited college or university (as full time is defined by that institute) and are primarily dependent on you for support and maintenance. To ensure prompt and accurate claims processing, this proof must be provided to Consociate for each semester of full-time student status.

Eligibility will also be extended for unmarried children over age 19 who are primarily dependent upon you and who are incapable of self-sustaining employment due to mental retardation or physical handicap. Disabled children are eligible only if they suffered their disability prior to turning 19 years old. You must provide proof of your child’s disability within 60 days of his or her turning 19 and annually from then on.

For purposes of Plan coverage, a child is considered “primarily dependent on you for support and maintenance” if he or she meets the definition of a tax dependent as modified for health coverage

purposes. Most commonly, your child will be a tax dependent for health coverage purposes as a “Qualifying Child” under Section 152 of the Code, as follows:

Qualifying Child. A child is considered your “Qualifying Child” under IRS rules if he or she meets all of these requirements:

- The child is under age 19, or under age 24 and a full-time student, or is a child of any age who is totally and permanently disabled;
- The child has the same principal place of residence as you for more than 50% of the year. Temporary absences due to special circumstances, such as illness; and education, business, vacation or military service, are not treated as absences; and
- The child does not provide over 50% of the child’s own financial support for the year.

Qualifying Relative. If your child is not your Qualifying Child, the child may still be your tax qualified dependent for health plan purposes, if the child meets all of the requirements of a “Qualifying Relative,” as follows:

- You provide more than 50% of the child’s financial support for the year; and
- The child is not a Qualifying Child of another taxpayer for the year.

Special Rule for Children of Parents who are Divorced or Separated. A special exception applies in the case of a child of parents who are divorced or legally separated, or who live apart at all times during the last 6 months of the calendar year. In the case of such a child, you may cover the child under the Plan on a tax-free basis even if the child is not your “qualifying child” or “qualifying relative” as defined above if the child:

- receives over 50% of his or her support during the year from his or her parents;
- is in the custody of one or both parents for more than 50% of the year; and
- qualifies under Section 152(c) or 152(d) as a qualifying child or qualifying relative of one of the child's parents

The Plan may request documentation to support continued coverage no less than annually.

Eligibility for Continued Coverage for Dependent Students on Medically Necessary Leave of Absence

Effective January 1, 2010, the Plan provides continued coverage for a dependent child who is covered under the Plan as a student but loses his or her student status because he or she takes a medically necessary leave of absence from school.

As a result, if your child is no longer a student, as defined in the Plan, because he or she is on a medically necessary leave of absence, your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your child was:

- covered under the Plan, and

- enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a “medically necessary leave of absence” means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

- begins while the child is suffering from a serious illness or injury,
- is medically necessary, and
- causes the child to lose student status for purposes of coverage under the plan.

The coverage provided to dependent children during any period of continued coverage:

- Is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the Plan would otherwise terminate, and
- Stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the Plan is changed during this one-year period, the Plan must provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the Plan no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child’s treating physician must provide a written certification to the Plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

If your child is eligible for continued coverage under these provisions and loses coverage under the Plan at the end of the continued coverage period, continuation coverage under COBRA will be available at the end of the one-year coverage period and a COBRA notice will be provided at that time.

If I am not enrolled, may my dependents enroll?

No. If you are not participating in the Plan, none of your dependents will be eligible for coverage.

What if my spouse is eligible for other health coverage?

If your spouse has health coverage available from his or her employer, and you and your spouse elect not to cover your spouse under that employer’s health plan, you will be charged an additional \$250 monthly surcharge for covering your spouse under the Plan. If your spouse is covered under both his or her employer’s plan, and this Plan, you will not be charged this additional contribution.

ENROLLMENT AND PARTICIPATION

When can I enroll?

You may enroll yourself and your eligible dependents anytime within the 30 days of the date on which you first become eligible for coverage. To enroll, simply complete and return the forms provided by the Plan Administrator. If you do not enroll in 30 days, you will not be eligible to enroll until the next annual enrollment unless you are entitled to “special enrollment” due to loss of coverage, enrollment in another plan, or acquiring a new dependent, or you are permitted to change your elections due to a change in status event.

What is special enrollment?

A special enrollment period is a time other than the annual enrollment period when eligible employees and their eligible dependents can enroll in the plan. Special enrollments are allowed if one of the following events occurs:

- You acquire a new dependent due to marriage, birth, adoption or placement for adoption,
- You declined coverage under a DMH plan (either initially or during a subsequent open enrollment period) because you were covered under another group health care plan or health insurance coverage, and you then lose that coverage for any of the following reasons:
 - You or your dependents exhaust COBRA continuation coverage under another employer’s group health plan (other than due to failure to pay contributions or for cause)
 - Employer contributions toward the other group health plan coverage terminate, or
 - You or your dependents lose eligibility under the other group health plan or health insurance coverage (other than due to your failure to pay contributions or for cause), including:
 - As a result of legal separation, divorce, cessation of dependent status, death, termination or reduction in hours of employment,
 - In the case of an individual HMO policy, loss of coverage because you no longer reside or work in the service area,
 - In the case of a group HMO, loss of coverage because you no longer reside or work in the service area; provided that no other benefit package is available to you,
 - When you or your dependent incurs a claim that meets or exceeds a lifetime limit on all benefits, or
 - When a plan no longer offers any benefits to your class of similarly situated individuals.

Effective April 1, 2009:

- You or your dependent becomes ineligible for coverage under a Medicaid plan or a state child health plan, and as a result coverage is terminated, or
- You or your dependent becomes eligible for a premium assistance subsidy for the plan under Medicaid or the state child health plan.

For example, if you decline coverage because you are covered through your spouse’s health plan and your spouse becomes unemployed, you would be entitled to a special enrollment period. Also,

if you decline employer coverage because you are covered by COBRA, and you later exhaust your COBRA coverage, you would be entitled to a special enrollment period.

If you acquire a new dependent, you, your spouse and your new and current dependent child(ren) can **all** enroll as a result of the addition of the new dependent. In other words, if you adopt a child, that child is entitled to the special enrollment period because he or she is a new dependent. Additionally, your other dependent child(ren) who were eligible but were not previously enrolled also may enroll during this special enrollment period

The request for a change in coverage must be made within 30 days of the special enrollment event, subject to the following exceptions:

- If the event is reaching a lifetime limit on benefits under another group health plan, then the request must be made within 30 days of the date a claim is denied under the other group health plan due to the operation of a lifetime limit on all benefits, or
- If the event is you or your dependent becoming ineligible for coverage under a Medicaid plan or a state child health plan, or you or your dependent becoming eligible for a premium assistance subsidy for the plan under Medicaid or the state child health plan, then the request for a change in coverage must be made within 60 days of the date you lose coverage or become eligible for coverage, as applicable.

Special enrollment will be effective the first day of the month after you submit the proper forms. However, enrollments following a birth, adoption, or placement for adoption will be effective as of the date of the birth, adoption, or placement for adoption. You must complete the appropriate forms (available in Human Resources) to add a dependent even if you already have dependent coverage and adding a dependent will not affect your cost. Return your completed election change forms to Human Resources.

Can I resume participation in the Plan if I terminate employment and am later reinstated?

Yes, if you are a former Eligible Employee, you shall be eligible to resume participation in the Plan immediately upon rehire as an Eligible Employee. If you are rehired as an Eligible Employee within 30 days after terminating your employment (within the same Plan year), you must resume participation by utilizing the same coverage elections that were in place for you before your termination. If you are rehired as an Eligible Employee after having been terminated for more than 30 days, you may resume participation by making new coverage elections.

What if I receive a qualified medical child support order?

If a court requires coverage of a child under a qualified medical child support order, you must provide a copy of that order to the Plan Administrator. Benefits specified in the order will be provided under the Plan to the alternate recipient(s) identified in the order (the children), but only to the extent such benefits are provided for in the Plan. The Plan Administrator adopts a written procedure to determine whether a medical child support order is a qualified medical child support order. These procedures are available to you upon request.

What is a “pre-existing condition”?

A pre-existing condition is a physical or mental condition for which a health professional recommended or provided medical advice, diagnosis, care or treatment within the six months before your coverage took effect under the Plan.

For example, if you had a sore shoulder when you were hired by DMH but had not seen a doctor or other health professional in the previous six months, you would not have a pre-existing condition. On the other hand, if, three months before being hired, you had asked your general family doctor about the shoulder and she referred you to a specialist, then you would have a pre-existing condition.

Neither pregnancy nor genetic information is a pre-existing condition under our Plan.

Does our Plan provide benefits for pre-existing conditions?

Our Plan generally excludes coverage for 12 months for pre-existing conditions, but there are several important limitations on this rule.

- ◆ No exclusions are applied to children who had coverage within 30 days of their birth, adoption or placement for adoption, and have not since had a break in coverage of 63 or more days.
- ◆ The 12-month pre-existing condition limitation period will be reduced, day for day, by any period of “creditable coverage” that you or your dependents have at the time you become eligible to enroll.

What is “creditable coverage”?

Creditable coverage means health coverage under a program, policy or Plan, including group health plans, individual insurance policies, and government programs such as Medicare and Medicaid. If you experience a 63 day break in coverage (where you were not covered under a health plan of any kind), any coverage you had prior to that break in coverage will not be considered creditable coverage.

Before I enroll, how can I show the Plan Administrator that I have creditable coverage?

If you leave another job, your health plan or health insurer should give you a certificate indicating how much creditable coverage you and your dependents had earned. If you have one of these certificates, present it to DMH when you are hired. If you do not have a certificate, DMH will assist you, if requested, in getting one from a former employer or insurer.

If you cannot get a certificate, you may present any other evidence of creditable coverage to DMH. This might include a health insurance card, medical bills that indicate you had coverage, payroll stubs showing deductions for health premiums, or benefit plan claims records. As part of demonstrating your coverage, you will be asked to cooperate with DMH in verifying your previous coverage.

How do I enroll my family and myself in the Plan?

To enroll, you must complete and return the forms provided by DMH and you must select the coverage under PPO Plan or HDP Select (formerly HDP2500) as summarized in the Schedule of Benefits section of this SPD. Your coverage will not be effective until after you have selected a coverage option.

The primary difference between PPO Plan and HDP Select is the level of deductibles and the cost to you. Also, the HDP Select plan is designed to be compatible with a “health savings account,” a type of account that you may establish and maintain on your own through a bank or other financial institution. An HSA is an individual savings account that lets you save, invest and withdraw funds for eligible expenses on a tax-free basis. For more information, contact Human Resources.

May I ever change my coverage elections?

Once you choose to enroll in PPO Plan or HDP Select Plan, you generally may not change that election until the next annual enrollment. But there are some exceptions. First, as explained above, you may be able to change coverage options when you have a “special enrollment” right under the terms of the Plan. Second, you may be able to change coverage options when you experience a “change in status” and that change in status makes you or your dependent eligible or ineligible for this Plan or another employer-provided health plan. Finally, you may be eligible to change your elections when you start or end a leave of absence, as detailed below.

Open Enrollment. Annually, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the open enrollment period will become effective January 1st and remain in effect until the next January 1st unless there is a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse’s employment.

Effective January 1, 2010 and thereafter, a Plan Participant will default to no coverage under the Plan if he or she does not affirmatively elect coverage under the Plan during open enrollment for each Plan year pursuant to procedures established by the Plan Administrator.

The Employer retains the right to change the enrollment defaults for any given year. Plan Participants will receive detailed information regarding open enrollment from their Employer.

What is a “change in status” and how can I change my elections?

The following events are the “changes in status” under the Plan:

- marriage or divorce;
- death of a spouse;
- birth, adoption, or death of a child;
- loss of coverage due to a change in your spouse’s employment status; or

- your spouse becoming ineligible for health benefits due to an employer's actions or union negotiations.

If you participate in the Plan and one of these events makes you or your spouse or dependent eligible, or ineligible, for coverage under this Plan or another employer-provided health plan, you will be eligible to change your elections for the remainder of the Plan year; provided your election is consistent with the change in status.

To change a coverage election, you must complete the appropriate forms within 30 days of the change in status. You must complete the appropriate forms to add a dependent even if you already have dependent coverage and adding a dependent will not affect your cost. Your election change will be effective as of the first day of the month after you submit the proper forms.

What happens to my health coverage if I go on an FMLA leave?

If you are on a leave under the Family Medical Leave Act ("FMLA"), coverage for you and your dependents will be continued under the Plan so long as you make any required payments. You will pay your contributions monthly on an after-tax basis in an amount and on a schedule set by the Plan Administrator and explained to you within a reasonable period of time after you begin the leave. If you fail to do so, your coverage will be cancelled and you will not be able to resume coverage until you return from the leave.

Of course, you may also elect to stop coverage for you and your dependents while you are on leave by filling out forms provided by the Plan Administrator. When you return to work, you will be eligible to resume your participation.

If you do not return to employment from your FMLA leave, you would be eligible for COBRA continuation coverage as explained later in this SPD.

What if I am on a leave that is not FMLA leave?

You will also be able to continue your coverage if you're on a leave other than FMLA leave – such as military leave under the Uniformed Services Employment and Reemployment Rights Act, or leave that is available under Illinois law for victims of sexual or domestic abuse. If you are on non-FMLA leave, the coverage you have in place for you and your dependents will continue during your leave, provided that you make any required contributions on time and that you remain an employee of DMH. If your leave is paid leave, your contributions will be deducted from your paycheck; if it is unpaid leave, you will have to make contributions in an amount and on a schedule set by the Plan Administrator and explained to you within a reasonable period of time after you begin the leave. If you fail to make payments on time, your coverage will be cancelled and you will not be able to resume coverage until you return from leave.

Of course, you may also elect to stop coverage for you and your dependents while you are on leave by filling out forms provided by the Plan Administrator. When you return to work, you will be eligible to resume your participation.

Once you have been out on leave for six months, your employment will be terminated under the HR policies of DMH. At this point, if you continued your coverage while on the leave, you would be eligible for COBRA continuation coverage as explained later in this SPD.

Must I be pre-certified before entering the hospital?

All Hospital admissions require pre-certification. For pre-certification, call American Health Holdings at 1-866-345-3509. If you do not pre-certify, you will be subject to a penalty of 50% of your eligible expenses for that admission. However, your physician does not need to pre-certify your hospital stay when he is prescribing a maternity length of stay that is 48 hours or less for vaginal delivery or 96 hours or less for cesarean delivery.

What is the utilization review company and what role does it play under our Plan?

The utilization review company is American Health Holdings. American Health Holdings is responsible for reviewing certain services to make sure that they are or were Medically Necessary. You must contact American Health Holdings to obtain pre-certification before you are admitted into the hospital for a scheduled stay or procedure. If you do not obtain precertification for your hospital stay, your benefits will be reduced by 50% (and may be denied if the services were not medically necessary).

The role of American Health Holdings is to help ensure that you and your dependents receive necessary and appropriate medical care, while avoiding unnecessary expenses. In addition to precertification services, American Health Holdings reviews emergency hospitalizations (after your admission), reviews whether you need to stay in the hospital longer than they originally certified, and assists in certifying services planned for your discharge. American Health Holdings also provides case management services, which are more fully discussed below.

What are case management services?

American Health Holdings provides case management services under our Plan. If you have a catastrophic condition, you can use a case manager from American Health Holdings to help manage and coordinate your care. Your case manager may determine that alternative treatments may be of value to you. Even if the alternative treatment is not specifically covered under the Plan, the Plan will pay for those alternative treatments if the Plan Administrator approves the case manager's treatment plan. Your use of a case manager is completely voluntary, but alternative treatments are only covered under our Plan if they are part of an approved case manager's treatment plan.

HEALTHY LIFESTYLE INITIATIVE PROGRAM

If you elect to participate in the PPO Plan, you can also benefit from participating in the Healthy Lifestyle Initiative Program. The program is a criteria-based incentive program that offers a financial award to employees who satisfy certain healthy-lifestyle criteria. The program gives you the opportunity to accumulate award points toward your PPO plan deductible in five program categories. The program's objective is for you to be an active partner in managing your medical condition or maintaining a healthy lifestyle for optimum health. Employee participants and their spouse and dependent child participants in the PPO Plan have the opportunity to complete the Healthy Lifestyle Initiative Program each calendar year.

Healthy Lifestyle Initiative Program Categories

The program categories are:

- 2010 Prevention Plan health risk assessment and blood tests -- The health risk assessment is a confidential evaluation tool that is designed to empower employees with personalized health information. Knowledge leads to positive lifestyle choices, and enables you to make responsible health decisions
- Non-smoker for 12 months or more
- Blood pressure below 140/90
- Glucose values less than 110 mg/deciliter
- Cholesterol LDL less than 160

For each Healthy Lifestyle Initiative Program category that you satisfy, you will receive a credit of \$50 toward your PPO plan deductible for the year. The maximum award you can earn toward your deductible for the plan year is \$250 for single coverage, and \$450 for family coverage. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the incentive under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, contact _____ at _____ regarding an alternative way to qualify for the reward.

Program Periods

To be eligible for Healthy Lifestyle Initiative Program credits, you or your spouse must follow these requirements:

TOBACCO USE

Individuals who wish to qualify for this health credit may not have used cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, or any other tobacco product for the past twelve (12) months and state that they will not use any of these or similar products in the future. (Physicians may use their discretion to certify compliance for children under 14 without asking the child.)

BLOOD PRESSURE

The American Heart Association recommended blood pressure levels per mm Hg are:

Normal Systolic <120 and Diastolic <80
Acceptable Systolic 120-140 and Diastolic 80-90

These levels can be achieved with appropriate medicine and still meet the criteria. Readings of Systolic greater than 140 mm Hg or Diastolic greater than 90 mm Hg do not qualify for the health credit.

CHOLESTEROL

The American Heart Association recommended cholesterol levels per mg/dl are:

	<u>LDL</u>
Desirable	100 to 129
Acceptable	130 to 160

These levels can be achieved with appropriate medicine and still meet the criteria. It is suggested that a fasting lipoprotein profile should be conducted if borderline values are not met. Physicians may use their discretion to certify that a child qualifies for this credit without testing the child.

GLUCOSE VALUES

Health care providers conduct a Fasting Plasma Glucose Test (FPG) or an Oral Glucose Tolerance Test (OGTT). Either test can be used to diagnose pre-diabetes or diabetes. The American Diabetes Association recommends the FPG because it is easier, faster, and less expensive to perform.

Desirable Less than 110

The level can be achieved with appropriate medicine and still meet the criteria.

How to Receive Your Healthy Lifestyle Initiative Program Credit

Your Health Lifestyle Initiative Program credits will be automatically credited toward your PPO Plan deductible for the year. The credits are not paid out to you if you do not incur reasonable expenses toward your deductible, and your credits for one year do not roll over to the next year if you do not use them toward your deductible for the year.

SCHEDULE OF BENEFITS

PPO Plan DMH Health Plan Summary Effective January 1, 2010			
	Decatur Memorial Hospital	Consociate Care PPO Providers	Non-Network Providers
Maximum Lifetime Benefit Amount	\$2,000,000	\$1,000,000	
Calendar Year Deductible			
Single Coverage	\$1,250*	\$2,500*	\$5,000
Per Family Unit	\$2,500*	\$5,000*	\$10,000
Coinsurance Level	80%	70%	50%
Calendar Year Out-Of-Pocket Maximum			
Single Coverage	\$2,250	\$4,500	Unlimited
Per Family Unit	\$4,500	\$9,000	Unlimited
	DMH Out-of-Pocket Expenses will be credited toward Consociate Care Out-of-Pocket Maximums		
*The Lifestyle initiative program will require employee and family members to submit a certification form from their physician in order to receive credits. Please see Summary Plan Description for further information.			
The Plan will pay the designated percentage of covered charges until the out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the Calendar Year unless stated otherwise.			
Hospital Services (Services at St. Mary's Hospital, Decatur, IL, are excluded from any coverage, unless it is a service that is not provided at DMH!)			
Room and Board	80% of the semi-private room rate after Deductible	70% of the semi-private room rate after Deductible	50% of the semi-private room rate after Deductible
Intensive Care Unit	80% of the hospital's ICU Charge after Deductible	70% of the hospital's ICU Charge after Deductible	50% of the hospital's ICU Charge after Deductible
Emergency Room Treatment (Non-emergent care is available through Doctor's Family Practice and CHS Urgent Care.)	80% after Deductible (50% Reduction for non-emergent treatment)	70% after Deductible (50% Reduction for non-emergent treatment)	50% after Deductible
Skilled Nursing Facility (Acute Care Hospital)	80% of one-half the Hospital average semi-private room and board rate	70% of one-half the Hospital average semi-private room and board rate	50% of one-half the Hospital average semi-private room and board rate
	Calendar Year Maximum Benefit of 180 days.		
Physician Services			
Inpatient Visits	80% after deductible	70% after deductible	50% after deductible

PPO Plan
DMH Health Plan Summary
Effective January 1, 2010

	Decatur Memorial Hospital	Consociate Care PPO Providers	Non-Network Providers
Office Visits	100% after a \$35 co-pay (Co-pay only applies to office visits, not ancillary services)	100% after a \$35 co-pay (Co-pay only applies to office visits, not ancillary services)	50% after deductible
Surgery	80% after deductible	70% after deductible	50% after deductible
Central Illinois Surgery Center	80% after deductible	N/A	No Coverage
Home Health Care	80% after deductible	70% after deductible	50% after deductible
	Calendar Year Maximum Benefit of 60 visits		
Outpatient Private Duty Nursing	80% after deductible	70% after deductible	50% after deductible
Hospice Care	80% after deductible	70% after deductible	50% after deductible
	Lifetime Maximum Benefit of 180 days (inpatient & outpatient)		
Ambulance Service	80% after deductible		
Jaw Joint / TMJ	80% after deductible	70% after deductible	50% after deductible
	Calendar Year Maximum Benefit of \$2,500. Lifetime of \$10,000.		
Occupational Therapy	80% after deductible	70% after deductible	50% after deductible
	Calendar Year Maximum Benefit of 40 visits		
Speech Therapy	80% after deductible	70% after deductible	50% after deductible
	Calendar Year Maximum Benefit of 40 visits		
Physical Therapy	80% after deductible	70% after deductible	50% after deductible
	Calendar Year Maximum Benefit of 40 visits		
Durable Medical Equipment	80% after deductible	70% after deductible	50% after deductible
Prosthetics	80% after deductible	70% after deductible	50% after deductible
Orthotics	80% after deductible	70% after deductible	50% after deductible
	Calendar Year Maximum Benefit of \$300		
Special Procedure Scans (CT, MRI & PET Scans)	Deductible, \$250.00 Co-pay, then 80%	Deductible, \$250.00 Co-pay, then 80%	Deductible, \$250.00 Co-pay, then 50%
Mental Disorders			
Inpatient	Not Available	70% after deductible	50% after deductible
Partial Hospitalization	Not Available	70% after deductible	50% after deductible
Outpatient	Limited coverage to include office visits to a Physician for attention deficit hyperactivity disorder and any lab charges to monitor drug level maintenance for A.D.D., which are covered at 80%	Limited coverage to include office visits to a Physician for attention deficit hyperactivity disorder and any lab charges to monitor drug level maintenance for A.D.D., which are covered at 70%	Limited coverage to include office visits to a Physician for attention deficit hyperactivity disorder and any lab charges to monitor drug level maintenance for A.D.D., which are covered at 50%
	Outpatient assistance is	Outpatient assistance is	Outpatient assistance is

PPO Plan
 DMH Health Plan Summary
 Effective January 1, 2010

	Decatur Memorial Hospital	Consociate Care PPO Providers	Non-Network Providers
	available through the Employee Assistance Program.	available through the Employee Assistance Program.	available through the Employee Assistance Program
Substance Abuse			
Inpatient	Not Available	70% after deductible	50% after deductible
Partial Hospitalization	Not Available	70% after deductible	50% after deductible
Inpatient/Partial Hospitalization Combined	Not Available	70% after Deductible	50% after Deductible
Preventive Care			
Routine Well Newborn Care (Inpatient care)	80% after Deductible	70% after Deductible	No Coverage
Routine Well Child Care Age 1 to 17, including legally required school physicals and immunizations.	100% Coverage to \$1000.00. Calendar Year Maximum \$1000.00	100% Coverage to \$1000. Calendar Year Maximum \$1000.00	No Coverage
Adult Well Care (Age 18 and older)	100% Coverage to \$1000 Calendar Year Maximum Benefit of \$1000	No Coverage	
All Routine Well Child Care and Adult Well Care includes office visits, routine physical examination, Laboratory blood test, x-rays and immunizations. Requires separate wellness visit and may not be used in conjunction with an illness visit.			
Organ Transplants	80% after deductible	70% after deductible	50% after deductible
*Bariatric Surgery or Procedures *Benefits apply only for Employees and not Dependents	70% after deductible (Participant Coinsurance does not apply toward maximum out-of-pocket limits.) Only one (1) medically necessary bariatric surgery or procedure (for morbid obesity) will be covered during an Employee's lifetime.	No Coverage	No Coverage

PPO Plan DMH Health Plan Summary Effective January 1, 2010			
	Decatur Memorial Hospital	Consociate Care PPO Providers	Non-Network Providers
Infertility – Diagnosis and Assessment Only	80% after deductible	70% after deductible	50% after deductible
Maximum Lifetime Benefit of \$1,000			
Pharmacy Benefits (Only available through the DMH Physician’s Plaza Pharmacy) Biologics (including, but not limited to Enbrel, Humira, Raptiva, Amevive, and Remicade) are covered under the Medical Plan, not the Prescription Co-pay.			
Generic Drug Co-pay	\$10	Not Covered	Not Covered
Brand Name Drug Co-pay	\$35 (Brand Name Drugs are not covered if there is a generic drug available)	Not Covered	Not Covered
Special Use Drugs Contact the Physician Plaza Pharmacy for details	\$60	Not covered	Not covered
Maintenance Drugs Contact the Physician Plaza Pharmacy or check the DMH Intranet for a complete list.	90 day supply per script 2 times normal co-pay	Not covered	Not covered

HDP Select (High Deductible Health Plan)

DMH Health Plan Summary

Effective January 1 2010

	Decatur Memorial Hospital	Consociate Care PPO Providers	Non-Network Providers
Maximum Lifetime Benefit Amount	\$2,000,000 (aggregate of network and non-network benefits)		\$1,000,000
Calendar Year Deductible			
Per Covered Person	\$2,500	\$5,000	\$7,500
Per Family Unit	\$5,000	\$7,500	\$10,000
Coinsurance Level	90%	80%	50%
Calendar Year Out-Of-Pocket Maximum			
Per Covered Person	\$4,000	\$8,000	Unlimited
Per Family Unit	\$8,000	\$16,000	Unlimited
	DMH Out-of-Pocket Expenses will be credited toward Consociate Care Out-of-Pocket Maximums		
The Plan will pay the designated percentage of covered charges until the out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the Calendar Year unless stated otherwise.			
Hospital Services (Services at St. Mary's Hospital, Decatur, IL, are excluded from any coverage, unless it is a service that is not provided at DMH!)			
Room and Board	90% of the semi-private room rate after Deductible	80% of the semi-private room rate after Deductible	50% of the semi-private room rate after Deductible
Intensive Care Unit	90% of the hospital's ICU Charge after Deductible	80% of the hospital's ICU Charge after Deductible	50% of the hospital's ICU Charge after Deductible
Emergency Room Treatment (Non-emergent care is available through Doctor's Family Practice and CHS Urgent Care.)	90% after Deductible (50% Reduction for non-emergent treatment)	80% after Deductible (50% Reduction for non-emergent treatment)	50% after Deductible
Skilled Nursing Facility (Acute Care Hospital)	90% of one-half the Hospital average semi-private room and board rate	80% of one-half the Hospital average semi-private room and board rate	50% of one-half the Hospital average semi-private room and board rate
	Calendar Year Maximum Benefit of 180 days.		
Physician Services			
Inpatient Visits	90% after deductible	80% after deductible	50% after deductible
Office Visits (after deductible & applies to OOP)	100% after a \$35 co-pay (Co-pay only applies to office visits, not ancillary services)	100% after a \$35 co-pay (Co-pay only applies to office visits, not ancillary services)	50% after deductible
Surgery	90% after deductible	80% after deductible	50% after deductible
Central Illinois Surgery Center	90% after deductible	80% after deductible	50% after deductible
Home Health Care	90% after deductible	80% after deductible	50% after deductible

HDP Select (High Deductible Health Plan)

DMH Health Plan Summary

Effective January 1 2010

	Decatur Memorial Hospital	Consociate Care PPO Providers	Non-Network Providers
	Calendar Year Maximum Benefit of 60 visits		
Outpatient Private Duty Nursing	90% after deductible	80% after deductible	50% after deductible
Hospice Care	90% after deductible	80% after deductible	50% after deductible
	Lifetime Maximum Benefit of 180 days (inpatient & outpatient)		
Ambulance Service	90% after deductible		
Jaw Joint / TMJ	90% after deductible	80% after deductible	50% after deductible
	Calendar Year Maximum Benefit of \$2,500. Lifetime of \$10,000.		
Occupational Therapy	90% after deductible	80% after deductible	50% after deductible
	Calendar Year Maximum Benefit of 40 visits		
Speech Therapy	90% after deductible	80% after deductible	50% after deductible
	Calendar Year Maximum Benefit of 40 visits		
Physical Therapy	90% after deductible	80% after deductible	50% after deductible
	Calendar Year Maximum Benefit of 40 visits		
Durable Medical Equipment	90% after deductible	80% after deductible	50% after deductible
Prosthetics	90% after deductible	80% after deductible	50% after deductible
Orthotics	90% after deductible	80% after deductible	50% after deductible
	Calendar Year Maximum Benefit of \$300		
Special Procedure Scans (CT, MRI & PET Scans)	Deductible, \$250.00 Co-pay, then 90%	Deductible, \$250.00 Co-pay, then 80%	Deductible, \$250.00 Co-pay, then 50%
Mental Disorders			
Inpatient	Not Available	80% after deductible	50% after deductible
Partial Hospitalization	Not Available	80% after deductible	50% after deductible
Outpatient	Limited coverage to include office visits to a Physician for attention deficit hyperactivity disorder and any lab charges to monitor drug level maintenance for A.D.D., which are covered at 90% Outpatient assistance is available through the Employee Assistance Program.	Limited coverage to include office visits to a Physician for attention deficit hyperactivity disorder and any lab charges to monitor drug level maintenance for A.D.D., which are covered at 80% Outpatient assistance is available through the Employee Assistance Program.	Limited coverage to include office visits to a Physician for attention deficit hyperactivity disorder and any lab charges to monitor drug level maintenance for A.D.D., which are covered at 50% Outpatient assistance is available through the Employee Assistance Program.

HDP Select (High Deductible Health Plan)

DMH Health Plan Summary

Effective January 1 2010

	Decatur Memorial Hospital	Consociate Care PPO Providers	Non-Network Providers
Substance Abuse			
Inpatient	Not Available	80% after deductible	50% after deductible
Partial Hospitalization	Not Available	80% after deductible	50% after deductible
Inpatient/Partial Hospitalization Combined	Not Available	80% after Deductible	50% after Deductible
Preventive Care			
Routine Well Newborn Care (Inpatient Care)	90% after Deductible	80% after Deductible	No Coverage
Routine Well Child Care up to 17, including legally required school physicals and immunizations.	100% Coverage up to \$1000.00 maximum benefit per covered dependent per calendar year	100% Coverage up to \$1000.00 maximum benefit per covered dependent per calendar year	No Coverage
Adult Well Care (Age 18 and older)	100% Coverage up to \$1000.00 maximum benefit per covered individual per calendar year		No Coverage
All Routine Well Child Care and Adult Well Care includes office visits, routine physical examination, Laboratory blood test, x-rays and immunizations. Requires separate wellness visit and may not be used in conjunction with an illness visit.			
Organ Transplants	90% after deductible	80% after deductible	50% after deductible
*Bariatric Surgery or Procedure, or Lap Band Bariatric Surgery or Procedure *Benefits apply only for Employees and not Dependents	70% after deductible (Participant Coinsurance does not apply toward maximum out-of-pocket limits.) Only one (1) medically necessary bariatric surgery or procedure OR one (1) medically necessary lap band bariatric surgery or procedure (for morbid obesity) will be covered during an Employee's lifetime.	No Coverage	No Coverage

HDP Select (High Deductible Health Plan)

DMH Health Plan Summary

Effective January 1 2010

	Decatur Memorial Hospital	Consociate Care PPO Providers	Non-Network Providers
Infertility – Diagnosis and Assessment Only	90% after deductible	80% after deductible	50% after deductible
Maximum Lifetime Benefit of \$1,000			
Pharmacy Benefits (Only available after the deductible is met and through the DMH Physician’s Plaza Pharmacy) Biologics (including, but not limited to Enbrel, Humira, Raptiva, Amevive, and Remicade) are covered under the Medical Plan, not the Prescription Co-pay.			
Generic Drug Co-pay	\$10 after deductible	Not Covered	Not Covered
Brand Name Drug Co-pay	\$35 after deductible (Brand Name Drugs are not covered if there is a generic drug available)	Not Covered	Not Covered
Special Use Drugs Contact the Physician Plaza Pharmacy for details	\$60 after deductible	Not covered	Not covered
Maintenance Drugs Contact the Physician Plaza Pharmacy or check the DMH Intranet for a complete list.	90 day supply per script 2 times normal co-pay After deductible	Not covered	Not covered

Prescription Drug Benefit

- All prescriptions must be filled at the Physicians Plaza Pharmacy located on the DMH Campus, Plaza East.
- 30-day supply allowed per prescription (90-day supply allowed for maintenance medications, as defined below).

What if a generic equivalent is available?

If a generic equivalent is available, the Plan will only cover the cost of the generic drugs. If you or your physician chooses to use name brand prescription drugs where a generic is available, the prescription drug is not covered under the Plan and you will be required to pay the full cost of the prescription drug.

How does DMH determine what drugs are covered under the prescription drug plan?

The prescription drug plan uses a formulary. Under the formulary, certain types of drugs are only covered if a specific brand of drug is used. The pharmacist will contact your physician to request that a prescription be changed to a formulary drug. If you or your physician elect to use a non-formulary drug, you will be required to pay for the full cost of the non-formulary prescription drug. For specific information regarding which drugs are included in the formulary, contact Plaza Pharmacy at 876-5566 or 876-6250.

Biologics, including but not limited to Enbrel, Humira, Raptiva, Amevive, and Remicade, are covered under the Plan, not the prescription plan co-payment.

What happens if I need to get a prescription outside of Physician's Plaza Pharmacy's normal operating hours in an emergency situation?

If you need to have an emergency prescription filled when Physician's Plaza Pharmacy is not open, you may go to any pharmacy. You will be required to pay full price for the prescription at the time of purchase and may be eligible for reimbursement for designated medications. Additional information and claim forms are available from Human Resources. An emergency prescription includes any medication (i.e. antibiotics, pain medications, cardiovascular drugs, etc.) where the delay in receiving this medication would have a serious, adverse or life threatening affect on the patient.

What are maintenance medications and how can I purchase them in the most economical manner?

Maintenance medications are defined as medications prescribed by a physician for regular (i.e., daily) use and includes (but are not limited to) drugs like: heart/ulcer/blood pressure, allergy, arthritis, antidepressants, growth hormones, etc. Maintenance medications are eligible for a three (3) month supply at a cost of two (2) co-pays after the deductible. Plaza Pharmacy has a complete list of eligible medications.

Deductibles, Co-payments and Out-of-Pocket Maximums

What is a deductible carry-over?

Eligible expenses incurred during the last 90 days of a Plan year and applied toward the deductible for that Plan year will also be applied toward the deductible for the next Plan year. For example, if you satisfy \$100 of your deductible during October, November and December, your deductible for the next Plan year will be reduced by that \$100 of the deductible you paid in the last 90 days before the new Plan year begins. Please note that this deductible carryover does not apply to the DMH network HDP Select option.

What are the deductibles and co-payments under the Plan?

The deductibles and co-payments vary depending on which coverage option you elect:

- Under the DMH network PPO Plan option, there is a \$1,250 deductible if you have single coverage (\$2,500 for family coverage), but no co-payment for inpatient admissions. There is a \$2,500 Plan year deductible if you have single coverage (\$5,000 for family coverage) for services received from Consociate Care and \$5,000 if you have single coverage (\$10,000 for family coverage) for non-network providers. Also, there is a \$35.00 co-payment for outpatient physician office visits for physician services received from DMH physicians or from network providers (and the Plan pays for 100% of the benefit after the co-pay).
- Under the DMH network HDP Select option (the high-deductible option that is designed to work in conjunction with a “health savings account”), there is a \$2,500 deductible if you have single coverage (\$5,000 for family coverage). There is a \$5,000 Plan year deductible for single coverage (\$7,500 for family coverage) for services received from Consociate Care, and \$7,500 for single coverage (\$10,000 for family coverage) for services received from non-network providers. Also, there is a \$35.00 co-payment for outpatient physician office visits for physician services received from DMH physicians or from network providers (and the Plan pays for 100% of the benefit after the co-pay).

What about out-of-pocket maximums?

Again, the out-of-pocket maximum varies depending on the coverage option you select:

- Under the PPO Plan option, for services received from DMH, unless otherwise specified, the Plan will pay 80% of eligible expenses until you have paid an out-of-pocket maximum of \$2,250 (or a maximum of \$4,500 per family). Thereafter, the Plan will pay 100% of the eligible expenses for the remainder of the Plan year (unless stated otherwise). For services received from network providers, unless otherwise specified, the Plan will pay 70% of eligible expenses until you have paid an out-of-pocket maximum of \$4,500 (or a maximum of \$9,000 per family). Thereafter, the Plan will pay 100% of the eligible expenses for the remainder of the Plan year (unless stated otherwise). For non-network providers, unless

otherwise specified, the Plan will pay 50% of eligible expenses, and there is no limit on the out-of-pocket expenses you incur.

- Under the HDP Select option, for services received from DMH, unless otherwise specified, the Plan will pay 90% of eligible expenses until you have paid an out-of-pocket maximum of \$4,000 (or a maximum of \$8,000 per family). Thereafter, the Plan will pay 100% of the eligible expenses for the remainder of the Plan year (unless stated otherwise). For services received from network providers, unless otherwise specified, the Plan will pay 80% of eligible expenses until you have paid an out-of-pocket maximum of \$8,000 (or a maximum of \$16,000 per family). Thereafter, the Plan will pay 100% of the eligible expenses for the remainder of the Plan year (unless stated otherwise). For non-network providers, unless otherwise specified, the Plan will pay 50% of eligible expenses, and there is no limit on the out-of-pocket expenses you incur.

How will the Plan pay for services that are not available at DMH?

The Plan will pay the appropriate Consociate Care PPO providers or Non-Network providers benefit level.

What is defined as Urgent/Emergency care?

Urgent/Emergency Care is defined as the necessary medical care needed to sustain life or limb. Examples include:

- ◆ Unusual chest pain or breathing difficulties
- ◆ Poisoning
- ◆ Excessive bleeding
- ◆ Sudden loss of strength, numbness or sensation to a limb
- ◆ Suspected fracture or broken bones
- ◆ Severe bites or burns

These conditions should be treated by the nearest emergency room or call 911. Non urgent/emergent problems include conditions such as vomiting, diarrhea, colds, non-severe headaches, sore throat/cough/runny nose, sprain/strain and body aches. You can minimize the out of pocket expenses by receiving treatment at an urgent care center or physician's office.

What if there is an emergency and there are no network hospitals in the vicinity?

In the event that emergency hospital services are needed as a result of an accident or for life threatening situations which require immediate medical attention, benefits will be paid as if services are received by a Consociate Care network provider, whether or not services were received by a network provider. In an emergency, you should go to the nearest hospital.

Do lifetime maximums apply under our Plan?

Yes. As you can see on the Schedule of Benefits in this SPD, lifetime maximums apply under PPO Plan and HDP Select. These maximums apply to all benefits that a participant has received through the Plan, regardless of which benefit option he or she was enrolled in at the time. For

example, if you hit the lifetime network maximum under the PPO Plan option, you would not be eligible to enroll in the HDP Select (and therefore have a new separate lifetime maximum). Instead, you would be ineligible for further benefits under the Plan.

Also, the Plan applies separate maximums for network coverage (\$2 million) and out-of-network (\$1 million) coverage, but in no event would your lifetime maximum ever be higher than the network lifetime maximum. For example, if you already had \$1 million worth of out-of-network benefits, you would not be eligible for an additional \$2 million in network coverage. Rather, you would be eligible for an additional \$1 million in network benefits – *i.e.*, up to the network coverage lifetime maximum.

ELIGIBLE EXPENSES

What are “eligible expenses” under our Plan?

Eligible expenses are expenses incurred by a participant on the recommendation of a physician for “medically necessary” services, treatments or supplies to treat non-work-related injuries or illnesses. Expenses that are “experimental” are not eligible expenses. The payment for eligible expenses is limited to the “reasonable and customary” charge (as explained in more detail below).

Must I obtain services from DMH if those medical services are available from DMH?

To receive the highest level of benefits, services must be provided by DMH if such services are available from DMH. If covered services are from another health care provider, those services will be paid at a lesser rate as shown on the Schedule of Benefits.

What does “medically necessary” mean?

To be eligible for coverage, expenses must be for “medically necessary” services, treatment, or supplies. “Medically Necessary” means that the care and treatment you receive is:

- ◆ recommended or approved by your doctor;
- ◆ consistent with your condition or with accepted standards of good medical practice;
- ◆ medically proven to be effective treatment for your condition;
- ◆ not performed mainly for your convenience or your doctor’s convenience;
- ◆ not conducted for research purposes; and
- ◆ the most appropriate level of services that can be safely provided to you.

To be medically necessary, the care and treatment you receive must meet all of the conditions described. Just because your doctor recommends or approves certain care does not mean that care is medically necessary.

The claims administrator will have rules and procedures that will assist the Plan in deciding whether care or treatment is medically necessary, and in reviewing care or treatment for medical necessity, will consult with an independent medical expert when needed. The Plan Administrator has the discretion to decide whether care or treatment is medically necessary.

What does “experimental” mean?

Expenses that are “experimental” are not covered under the Plan. “Experimental” means service, supplies, care or treatment that is not considered to be an accepted medical practice based on the standards accepted by the relevant medical community and by governmental agencies at the time you received the service, supply, care or treatment. The claims administrator will determine

whether a supply, service, care or treatment is experimental and will be guided by the following. The supply, service, care or treatment will be considered experimental if:

- ◆ the drug or device cannot be sold because it has not been approved by the FDA;
- ◆ the drug, device, medical treatment or procedure (or the informed consent document you sign) was reviewed or approved by the treating facility's Institutional Review Board or if federal law requires such review or approval;

Expenses that are excluded by the Plan are not eligible expenses and neither are amounts beyond the "reasonable and customary" charge for a service, treatment or supply. "Reasonable and customary" means the usual charges made in the local area where a particular service was rendered by others treating conditions similar in nature and severity or, if less, the contracted rate with a provider. Consociate, on behalf of DMH, makes this determination.

What is a "reasonable and customary" charge?

A reasonable and customary charge is the charge which is not higher than the usual charge made by the provider for the care or service and does not exceed the usual charge made by most providers of like service in the same area. This charge is established by the claims administrator. In determining "reasonable and customary," the claims administrator will consider the nature and severity of the condition being treated and medical complications or unusual circumstances that require more time, skill, or expertise. For network providers, the reasonable and customary charge will be more than the contracted rate. If billed charges are less than the reasonable and customary charges, the Plan will reimburse actual billed charges.

What types of eligible expenses does our Plan cover?

The Plan covers four types of expenses – inpatient, outpatient, physician and miscellaneous – each of which is discussed in greater detail below.

Inpatient Expenses

Which hospital services are eligible expenses?

If you are under the direct care of a physician, your hospital expenses for the following services will be eligible expenses under the Plan:

- ◆ Bed, board and general nursing service (for a semi-private room, if available, a private room at DMH)
- ◆ Bed in an intensive care unit
- ◆ Drugs approved by the FDA for the planned use
- ◆ Use of operating room and other special treatment rooms
- ◆ Inpatient x-ray service (as part of covered medical care)
- ◆ Inpatient laboratory and pathology service (as part of covered medical care)
- ◆ Physical, occupational and speech therapy
- ◆ Respiratory therapy
- ◆ Oxygen and related equipment

Refer to the Schedule of Benefits for payment levels and limitations.

Is a private room an eligible expense under our Plan?

No. If you use a private room, your eligible expenses will be determined based on the hospital's average semi-private room rate. However, if you are a patient at DMH, the Plan will pay for a private room when available.

Does the Plan cover skilled nursing facility care?

The Plan pays for room and board in a skilled nursing facility (that is approved by Medicare) if all of the following conditions are met:

- ◆ the patient is confined as a bed patient in the facility;
- ◆ the confinement starts within 14 days of a hospital confinement of at least 3 days;
- ◆ the attending physician certifies that the confinement is needed to provide further care for the condition that caused the hospitalization; and
- ◆ the attending physician completes a treatment plan for the stay in the skilled nursing facility. The treatment plan must include a diagnosis, the proposed course of treatment, and the projected date of discharge.

The Plan will pay for up to 180 days of room, board and care at a skilled nursing facility per calendar year.

Do any special rules apply to hospital services for mothers and newborns?

Yes. If you or your spouse is hospitalized for childbirth, Plan coverage for the mother and newborn will not be reduced below 48 hours following a vaginal birth, or 96 hours following a cesarean section, unless the attending provider in consultation with the mother decides to discharge earlier.

Is routine nursery and physician care covered for a newborn?

Yes, if you are a Participant at the time of the birth and you enroll the newborn in the Plan within 30 days of birth, routine nursery and physician care is covered for your newborn. The Plan will cover routine well newborn nursery care (including room, board and other normal care) and routine physician care for the newborn. These charges are applied against the Plan of the newborn. This coverage is not available to a newborn baby of your covered dependent child.

Are expenses for pregnancy of my daughter and care for her newborn covered?

No. The Plan only provides coverage for pregnancy and newborn care to you or your spouse.

If I have a choice, should I be treated as an inpatient or an outpatient?

Outpatient. If you are initially hospitalized for diagnostic purposes or observation and surgery is performed, American Health Holdings will examine the charges. If it determines that the services could effectively have been performed on an outpatient basis, your room and board expense will not be covered as eligible expenses.

Outpatient Expenses

What is an outpatient?

Our Plan defines “outpatient” as registered to obtain services in a health care facility, but not registered for bed occupancy as an inpatient.

What sort of outpatient expenses are eligible expenses under our Plan?

These types of outpatient expenses are eligible expenses:

- ◆ Routine screening mammograms
- ◆ Diagnostic and laboratory procedures (including x-rays)
- ◆ Physician visits
- ◆ Routine well child care
- ◆ Occupational, speech and physical therapy
- ◆ Cardiac rehabilitation initiated within 12 weeks from the end of other treatment
- ◆ Radiation and chemotherapy
- ◆ Routine preventive care

Physician Services

What is a “physician” under our Plan?

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, Nurse Assistant, Nurse Practitioner, Nurse Aide in home care, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license, except for chiropractors.

What types of physician services does our Plan cover?

Four types of physician services are eligible expenses under our Plan – surgical services, inpatient medical care visits, emergency medical services and outpatient medical care visits.

Which surgical services are covered?

If you have the following surgical services performed by a physician while you are participating in the Plan, they will be eligible expenses covered under the Plan. Some of these services may be performed by a dentist or podiatrist, but such expenses will be eligible expenses only when they

could legally perform the services and the services would be payable if rendered by other physicians.

- ◆ Surgery (including oral surgery done to remove complete bony impacted teeth)
- ◆ Services by a nurse practitioner or physician's assistant
- ◆ Sterilizations (though not reversals)
- ◆ Surgical dressings
- ◆ Services related to home health care, hospice and private care
- ◆ Anesthetics and related services done as part of a covered surgery by a certified registered nurse anesthetist or a physician other than the operating physician
- ◆ Reconstructive surgery following a mastectomy

How are multiple surgical procedures covered?

If one surgeon performs multiple surgical procedures through the same incision, the primary procedure is paid on the basis of the reasonable and customary charge and each additional procedure is covered at 50% of the reasonable and customary charge. If two or more surgeons perform surgical procedures in different operative fields, the primary procedure for each surgeon is paid at the reasonable and customary charge. If an assistant surgeon is required, the eligible expense for the assistant surgeon will not exceed 20% of the surgeon's reasonable and customary charge.

What is the second and/or third opinion program?

The second and/or third opinion program is a program where benefits are provided for a second (and third, if necessary) opinion consultation to determine the medical necessity of an elective surgical procedure. An elective surgical procedure is a surgical procedure that can be scheduled in advance (not an emergency or life threatening). You or your dependents need not obtain a second (or third) opinion, but the second (or third) opinion may assist in providing you with alternative treatments to surgery. You should obtain a second (or third) opinion from a board-certified specialist who is not an associate of your attending physician and who is qualified in the appropriate medical specialty.

How are organ and tissue transplants covered?

Our Plan's coverage depends on where a transplant is performed. Our Plan uses a special network of transplant hospitals. If you use one of these network facilities, and that facility is designated to perform the type of transplant that you require, then the Plan will provide coverage at 80% after the deductible for: hospital and professional charges for assessment or evaluation and transplant-related care prior to transplantation; organ or bone marrow procurement; retransplantation services; and hospital and professional charges rendered within 1 year after discharge from the Hospital.

If you use a non-network facility or a network facility that is not designated by the Lifetrac Network to handle your specific type of transplant, the Plan provides no coverage.

Is hospice care covered?

Yes. Hospice care service and supplies are covered when the attending physician has diagnosed the participant's condition as being terminal. A condition is terminal when the participant is not expected to live more than 6 months and the physician has placed the participant under a hospice care plan. Please refer to the Schedule of Benefits for additional information related to hospice care coverage.

How does our Plan cover breast reconstruction following a mastectomy?

If you or your dependent elects breast reconstruction in connection with a mastectomy covered by the Plan, you will be eligible for coverage for reconstruction of a breast on which a mastectomy has been performed, surgery and reconstruction of another breast to produce a symmetrical appearance, and prostheses and physical complications at all stages of the mastectomy (including lymphedema). The Plan will also pay for one bra during each calendar year.

How are inpatient medical care visits covered?

If you or your dependent is an inpatient at a hospital, a medical care visit by a physician is an eligible expense. Also, if you or your dependent is transferred to a skilled nursing facility for treatment of the same condition within 14 days of your discharge from a hospital confinement of at least 3 days, medical care visits by a physician are an eligible expense.

What about home and office visits?

Home and office visits by a physician are eligible expenses under our Plan.

Miscellaneous Expenses

How are ambulance charges covered?

If you need to be taken from your home, the scene of an accident or other site of a medical emergency, charges for a certified ambulance to the nearest hospital that would be expected to have appropriate facilities will be eligible expenses under the Plan. Similarly, if you need to be taken by ambulance between hospitals or from a hospital to a skilled nursing facility or from either type of facility to your home, those ambulance charges will be eligible expenses.

Are there any important restrictions on covered nursing services?

Yes. The Plan will not ordinarily pay for the services of nurses who reside in your home or who are members of your immediate family.

Will our Plan pay a benefit for “durable medical equipment?”

Durable medical equipment is equipment that serves primarily a medical purpose and is not useful to someone without illness or injury, that can stand repeated use, and that is appropriate for home use. Your physician must certify that equipment is necessary for treatment, to improve the functioning of a malformed body member, or to compensate for loss of movement due to physical impairment.

Eligible expenses under the Plan include expenses for permanent internal equipment approved by the claims administrator, such as cardiac valves, internal pacemakers, and bone screws, nails and plates. The Plan also covers the rental (not to exceed the total cost) of external equipment designed for temporary therapeutic use.

Are dental services covered by our Plan?

Dental care and orthodontics are generally not eligible expenses. However, the Plan covers dentist or physician services required due to an accidental injury to the jaws, teeth, mouth or face.

What mental health and substance abuse treatment is covered by our Plan?

Our Plan covers inpatient treatment for alcohol and drug dependency and for mental or nervous conditions.

Our Plan limits coverage to office visits to a Physician for attention deficit hyperactivity disorder and any lab charges to monitor drug level maintenance for A.D.D. The Plan does not cover other outpatient treatment for alcohol and drug dependency or for mental or nervous conditions. However, up to eight (8) counseling sessions to determine course of treatment are provided under the DMH Employee Assistance Plan. Coverage beyond these sessions will not be eligible expenses under the Plan.

Please refer to the Employee Assistance Plan to determine what coverage is available for outpatient treatment for alcohol and drug dependency and for mental or nervous conditions.

Our Plan provides benefits for partial hospitalization for treatment for alcohol and drug dependency and for mental or nervous conditions. For more information about partial hospitalization, refer to the question below.

What is a partial hospitalization for mental health or substance abuse treatments?

You or your dependent may be treated for a mental disorder or substance abuse through a “partial hospitalization.” Partial hospitalization is an outpatient program that is designed for the diagnosis or active treatment of a mental disorder or substance abuse when there is:

- a reasonable expectation for improvements; or
- when it is necessary to maintain a patient’s functional level and prevent relapse.

The outpatient program is administered in a psychiatric facility. Treatment lasts for less than 24 hours, but more than 4 hours, per day and no charge is made for room and board.

Does the Plan cover any therapies?

Physical, occupational and speech therapy are all eligible expenses, and are all subject to limits summarized in the Schedule of Benefits.

What case management services are covered?

If you use a case manager through American Health Holdings, your case manager may determine that alternative treatments may be of value to you. Even if the alternative treatment is not specifically covered under the Plan, the Plan will pay for those alternative treatments if the Plan Administrator approves the case manager's treatment plan. Your use of a case manager is completely voluntary, but alternative treatments are only covered under our Plan if they are part of an approved case manager's treatment plan.

What medical treatment is covered for treatment of morbid obesity?

The Plan will cover one medically necessary Bariatric surgery or procedure OR Lap Band Bariatric surgery or procedure (for morbid obesity) performed at DMH. The Plan will only pay for one surgery or procedure, either a Bariatric Surgery/Procedure or a Lap Band Bariatric Surgery/Procedure, during an employee's lifetime; one of each such Surgery/Procedure is not available. Only employees, and not their dependents, are eligible for this benefit. There are different co-pays that apply to this benefit. The employee must pay for 30% of the benefit and the Plan will pay for 70%. The amount paid by the employee does not apply toward the employee's annual out of pocket maximum. Bariatric surgery or procedures for morbid obesity performed by hospitals or providers other than DMH are not covered under the Plan.

Which other benefits does our Plan cover?

- ◆ sterilization procedures
- ◆ initial contact lenses or glasses following cataract surgery
- ◆ initial purchase of a wig following chemotherapy
- ◆ initial purchase, fitting and repair of prosthetic devices
- ◆ Surgery assistance
- ◆ Splints, casts and other devices to treat fractures and dislocations
- ◆ initial purchase, fitting and repair of orthotic devices
- ◆ initial purchase, fitting and repair of prosthetic devices
- ◆ Medical/surgical dressings

EXCLUDED EXPENSES

What types of services and supplies are excluded from coverage under our Plan?

Several general exclusions under the Plan apply to all services and supplies. Also, certain types of care, certain items or expenses and certain providers of care are subject to more specific exclusions.

What are the general exclusions under our Plan?

The following types of services and supplies are excluded from coverage under our Plan:

- ◆ Those that the claims administrator determines are not “medically necessary” for a participant.
- ◆ Those that the claims administrator determines are “experimental.”
- ◆ Those related to the treatment or diagnosis of a Pre-Existing Condition, except as explained in the “Enrollment and Participation” section.
- ◆ Those that are not listed as covered in this booklet or in the Plan document.
- ◆ Those for any illness or injury for which benefits or compensation are available under any worker’s compensation, temporary disability, occupational disease or similar law (whether or not you actually make a claim for benefits or compensation).
- ◆ Those for which payment is available through any federal, state or related government (except that expenses incurred in a Veterans Administration hospital for non-military expenses can be eligible expenses).
- ◆ Those for treating any self-inflicted injury or illness, or for any illness or injury sustained as a result of any war or act of war.

Are there any other exclusions under the Plan?

Any illness or injury resulting from the following competitive hazardous activities are excluded from coverage under the Plan: scuba diving, mountain climbing (up to 13,000 feet or where ropes or guides are normally used), jet, snow and water-skiing, snowboarding, skydiving, amateur racing, piloting an aircraft, bungee jumping, spelunking, hang gliding and parachuting and any other sport or activity which exposes you to abnormal or extreme risk of injury.

Which specific items or expenses are excluded from coverage under our Plan?

- ◆ Lodging and travel expenses (except for ambulance services described in the booklet)
- ◆ Personal hygiene, comfort and convenience items (such as air conditioners, fitness equipment or corrective shoes)
- ◆ Eyeglasses or contact lenses (except cataract lenses) and examinations for related prescribing, fitting, or testing
- ◆ Hearing aids, earplugs or molds and related examinations

Which specific types of care or treatment are excluded from coverage under our Plan?

- ◆ Cosmetic (except to correct congenital deformities or conditions from injuries, tumors, or disease)
- ◆ Expenses of a transplant organ donor who is not participating in the Plan
- ◆ Dental or orthodontic care, or the extraction of teeth
- ◆ Charges for services received for an illness or injury caused by or contributed to by engaging in an illegal act or occupation
- ◆ Preventive care (unless specifically covered)
- ◆ Surgical sterilization reversal
- ◆ Sex change
- ◆ Radial keratotomy
- ◆ Educational or vocational testing
- ◆ Foreign travel for the sole purposes of obtaining medical services outside of the U.S.
- ◆ Hair loss
- ◆ Care, services or treatment that is not recommended and approved by a physician
- ◆ Smoking cessation
- ◆ Services rendered by a chiropractor or any spinal manipulation, care, or treatment
- ◆ Self-inflicted injury
- ◆ Weight reduction programs; exercise programs; surgical treatment of morbid obesity (except as otherwise provided under the Plan)
- ◆ Routine exams (unless specifically covered)
- ◆ Sleep disorders (unless medically necessary)
- ◆ Infertility care and treatment including drugs
- ◆ Outpatient mental health or substance abuse treatment
- ◆ Non-medical therapy
- ◆ Custodial care
- ◆ Eye care to correct nearsightedness and routine exams
- ◆ Complications of non-covered treatments
- ◆ Hearing aids and exams in connection with fitting of aids
- ◆ Pregnancy of a dependent daughter
- ◆ Replacement braces (e.g., leg, back, arm, neck)
- ◆ Any loss due to an act of war
- ◆ Services and supplies for any illness or injury, which may be covered by workers' compensation and related laws
- ◆ Illness or injury resulting from hazardous activities

Which types of care are excluded based on the provider?

- ◆ Services of a podiatrist (except specified surgical or surgical pathological services, or diagnostic x-ray services)
- ◆ Services or supplies provided by a close relative
- ◆ Services of a non-licensed health care provider

What types of prescription drug expenses are excluded?

- ◆ Charge for giving a covered prescription drug (e.g., charge for a nurse to inject insulin)
- ◆ Hypodermic syringes and or needles
- ◆ Drugs used for fertility treatment
- ◆ Experimental drugs
- ◆ Immunization agents or biological sera
- ◆ Drugs for smoking cessation or smoking deterrent patches
- ◆ Appetite suppressants and dietary supplements loss (see Special Use Drugs)
- ◆ Vitamins supplements (except for prenatal vitamins requiring a prescription)
- ◆ Devices of any type, even though a prescription is required for such device
- ◆ Drugs not approved by the FDA

COORDINATION OF BENEFITS

What is “coordination of benefits?”

Coordination means reducing payment levels to avoid duplication of benefits. If you or your dependents are eligible to receive benefits under both our Plan and another group health plan, your benefits may not exceed the total allowable expenses under our Plan. (“Allowable expenses” are the reasonable and customary or negotiated expenses that at least one of the plans covers in whole or in part.) So, one plan will coordinate its benefits with those provided by the other plan. For example, if our Plan normally pays 80% of an eligible expense and the other plan already paid 60%, our Plan would pay only the remaining 20%.

When the DMH Plan is the secondary plan, it pays benefits only after the benefits payable from the primary plan are determined. The benefits payable from the DMH Plan may be reduced so that the benefits paid by all plans do not exceed the total allowable expenses under the DMH Plan.

What sort of benefits does our Plan coordinate with?

Our Plan coordinates with: Medicare and other government benefit programs (except Medicaid); no-fault automobile insurance plans; employer or union plans; and other group health plans which cover you or your dependents. Individual coverage is not subject to these nonduplication, or coordination, rules.

What are primary and secondary plans?

When you are eligible to receive benefits under two different health plans, one plan will ordinarily pay benefits first without regard to the other plan. The plan that pays benefits first is called the primary plan. The other plan will reduce its benefits so that your total expenses do not exceed the allowable total. This other plan is called the secondary plan.

How does our Plan determine which plan is primary and which is secondary?

If one plan has no coordination of benefits rules, that plan generally will be primary and pay benefits first. If both plans have coordination of benefits rules, the determination will be made based on these rules:

- ◆ *Nondependent/Dependent.* The plan covering the patient as an employee is generally primary, and pays benefits before the plan covering the patient as a dependent or retiree.
- ◆ *Birthday Rule for Dependents.* If a dependent child is covered under both parents’ plans, the plan of the parent whose birthday comes first during the calendar year will be primary. This is called the “birthday rule.” If the other plan does not follow this rule, then the rules of that plan will determine the order of benefits.
- ◆ *Child of Separated or Divorced Parents.* If a dependent child of divorced or separated parents is covered under both parents’ plans, the plan of the parent with custody of the child usually pays benefits for the child first. If the parent with custody remarries, the stepparent’s plan pays second, and the plan of the parent without custody pays third. Still,

if a “qualified medical child support order” makes any one parent responsible for care, that parent’s plan always pays first.

- ◆ *Active or Inactive Employee.* A plan that covers the person as a laid-off or retired employee (or dependent of a laid off or retired employee) is secondary to a plan that covers the person as an employee, other than a laid-off or retired employee (or as a dependent of an employee (other than a laid-off or retired employee). If the other plan does not have this rule, and the plans do not agree on the order of benefits, then this rule does not apply.
- ◆ *Longer or Shorter Length of Coverage.* If none of the above rules determines the order of payment, then the plan that has covered the person longer pays before the plan that has covered the person for the shorter period of time.

Does our Plan coordinate benefits with Medicare?

Our Plan may coordinate benefits with Medicare, depending on your age and employment status.

How are benefits coordinated with Medicare if I am an active employee?

If you or any of your dependents are eligible for Medicare, the coordination of your benefits works differently from the above rules. A series of federal laws collectively referred to as the “Medicare Secondary Payer” (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children. In general, Medicare pays secondary to the following:

- The plan if you or any of your dependents is entitled to Medicare and entitled to Social Security disability benefits, but only while coverage under the plan is due to your “current employment status” under Medicare rules (generally (i) while you are actively working, or (ii) during the first six months while you are not actively working and are receiving disability benefits from an employer). If coverage under the plan is other than because of your “current employment status” (after your employment terminates or after the sixth month that you receive disability benefits), Medicare is primary.
- The plan if you or any of your dependents is suffering from end-stage renal disease (ESRD) (*i.e.*, on kidney dialysis or needing a kidney transplant), but only for the first 30 months of ESRD treatment (the 30-month period begins with the month in which eligibility for Medicare benefits for ESRD begins). Thereafter, Medicare is primary. When this provision determines that Medicare is primary, the plan pays secondary regardless of whether you or your dependent (whoever is eligible) has enrolled in Medicare.

If you and/or your covered dependent is eligible for Medicare, you may decline coverage from Decatur Memorial Hospital and elect Medicare as your coverage if you do so in writing to Human Resources. Should you make such an election, this plan would not pay benefits, as Medicare would be your only coverage.

How are benefits coordinated with Medicare if I am not an active employee?

If you or your spouse (who is also not an active employee) is eligible for Medicare, Medicare is primary regardless of your or your spouse's age. As the secondary plan, our Plan pays the difference between what Medicare pays and what our Plan would have paid without Medicare.

What are the Plan's rights under this Coordination of Benefits provision?

The Plan's rights under this coordination of benefits provision extend to all recoveries from an insurer or other third party (whether by litigation, arbitration, settlement of a claim, or otherwise), including a right to any property to which the original recovery is converted. The Plan may make a recovery under this coordination of benefits provision even if you are not made whole (i.e., compensated in full). If you do not fully cooperate with the Plan in its efforts to coordinate benefits and enforce its recovery rights, the Plan may reduce the amount payable to you or on your behalf for current or future expenses until the Plan has made a full recovery. In the event the Plan makes total payments that exceed the maximum amount to which you are entitled, the Plan shall have the right to recover the excess amount from persons to, or for, or with respect to whom, such excess payments were made, including, but not limited to, withholding payments otherwise available under the Plan. The Plan also reserves the right to bring legal action against you.

The Plan has a right to payment or reimbursement for any legal fees it expends in exercising its right of recovery. Also, the recovery rights of the Plan outlined in this provision will not be reduced to reflect your costs, including attorney fees, unless the Plan Administrator agrees, in writing, and in the exercise of the Plan Administrator's sole discretion.

CLAIMS PROCEDURE

What are the Plan's Claims Procedures?

The following questions and answers describe the claims procedures for the Plan. For all initial benefit determinations, the Claims Administrator is Consociate Group. However, claims that involve determinations of eligibility under the Plan should be filed with, and are determined by, the DMH Health Plan Appeals Committee (file eligibility claims at the Plan Administrator's address). For final appeals, the Plan Administrator (the Plan Administrative Committee for DMH) is the administrator for all appeals, whether they are "urgent care," "pre-service," or "post-service" claims.

How and when do I file claims for benefits?

Physicians and hospitals in the network will automatically submit your claim for services to Consociate Group. Consociate Group will pay the network provider for covered services. You do not need to submit a claim.

If you did not use a network provider, you will have to keep the itemized bills (paid or unpaid), complete a medical claim form or prescription claim form, as appropriate, and send the form with the bills to Consociate Group for payment. Claims must be submitted within one year from the date of the medical service received. You should send your written claims to:

Consociate Group
111 East Decatur Street
P.O. Box 1068
Decatur, IL 62521
(217) 423-7788 or 1-800-798-2422

Consociate Group will process the claim and send you an Explanation of Benefits (EOB) which will detail the amounts covered and paid to the appropriate providers. If you have paid the provider and are to be reimbursed from the Plan, your claim must include proof of payment. You will be responsible for paying to the provider any amounts not covered under the Plan due to exceeding the reasonable and customary charge, amounts applied to deductibles and coinsurance or any other restrictions that were applied to the claim.

If a claim is approved, how will it be paid?

Your claim would be paid by check issued to you, unless you have previously authorized payment to a physician or other provider of services or supplies.

What is an urgent care claim and how is it processed?

An "Urgent Care Claim" is a claim for medical care or treatment with respect to which the applicable time periods for the Plan Administrator to make non-urgent care determinations (i) could seriously jeopardize your health or your ability to achieve a full recovery; or (ii) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain

that could not be adequately managed without the care or treatment. If a physician with knowledge of your medical condition determines that a claim is an urgent care claim, the claim will be treated as such under the Plan. Otherwise, the Claims Administrator will determine whether a claim is an urgent care claim by applying the judgment of a prudent layperson with an average knowledge of health and medicine.

Once the Claims Administrator receives your Urgent Care Claim, the Claims Administrator will notify you of the benefit determination within 72 hours. If you do not provide sufficient information for the Claims Administrator to make a determination, the Claims Administrator will notify you, within 24 hours after the claim is filed, of the specific information necessary to complete the claim. You will have up to 48 hours to provide this information.

In the case of an Urgent Care Claim that is a request to extend the course of treatment beyond the period of time or number of treatments provided, the Claims Administrator will notify you of its benefit determination within 24 hours of receiving your claim, provided that your claim was received at least 24 hours before the end of the period or number of treatments. Otherwise, a decision will be issued according to the category your claim falls into at the time it is made (*i.e.*, urgent care, pre-service or post-service).

You may be notified of a benefit determination on an urgent care claim orally; however, you will be sent a written or electronic notice of the determination within 3 days of the oral notice.

What is a pre-service claim and how is it processed?

A “Pre-Service Claim” is any claim for benefits where the Plan conditions receipt of the benefit, in whole or in part, on advance approval of the benefit (for example, pre-certification or utilization review procedures).

After the Claims Administrator receives your Pre-Service Claim, the Claims Administrator will notify you of the benefit determination within 15 days. Within that time, the Claims Administrator may notify you that it requires an extension of up to 15 days indicating why an extension is necessary and the date the Claims Administrator expects to issue its decision. If an extension is necessary because you have failed to submit the information necessary to make a benefit determination, the notice will describe the specific information necessary to complete the claim. You will be given 45 days to provide this information.

If you attempt to file a Pre-Service Claim and your claim does not follow claim filing procedures, you will receive written, electronic or oral notice from the Claims Administrator within 5 days. The notice will explain the proper procedures to be followed in filing a claim. If the pre-service claim is an urgent care claim, the Claims Administrator will notify you of an improperly filed claim within 24 hours.

What is a post-service claim and how is it processed?

A “Post-Service Claim” is any claim for benefits where the Plan does not condition the benefits on advance approval of the benefits.

After the Claims Administrator receives your Post-Service Claim, the Claims Administrator will notify you of the benefit determination within 30 days, unless an extension of up to 15 days is necessary. If an extension is needed, the Claims Administrator will notify you during the initial 30-day period stating why an extension is necessary and the date on which the Claims Administrator expects to issue its decision. If an extension is necessary because you did not submit the information necessary to make a benefit determination, the notice will describe the required information, and you will be given 45 days to provide the information.

If the Plan reduces or terminates benefits that you are receiving through an ongoing course of treatment, the Claims Administrator will notify you well enough in advance to allow you to appeal before your benefit is actually reduced or terminated.

What happens if I receive an Adverse Benefit Determination (a denial) of a claim?

An Adverse Benefit Determination is a denial, reduction or termination of a benefit or a failure to provide or make a benefit payment (in whole or in part). This includes a denial, reduction, termination or failure to provide or make payment based on a determination of ineligibility, and a reduction or termination of benefits that are part of an ongoing course of treatment. Adverse Benefit Determinations also include (i) a denial, reduction or termination of a benefit or a failure to provide a benefit or make payment (in whole or in part) resulting from a utilization review or pre-certification; and (ii) a failure to cover a supply or service on the grounds that it is experimental, investigational or not medically necessary or appropriate.

If the response to your claim is an Adverse Benefit Determination, the Claims Administrator will send you a notice that will 1) be written in a manner designed to be understandable; 2) include the specific reasons for the Adverse Benefit Determination; 3) refer to the Plan provisions on which the determination was based; 4) describe any additional material or information necessary for you to perfect the claim and explain why the additional material is necessary; 5) explain the Plan's review procedures and the time limits applicable; 6) inform you that, upon request and free of charge, you will be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim; 7) include a statement of your right to bring a civil action under Section 502(a) of ERISA after receiving a final Adverse Benefit Determination upon appeal; 8) include a copy of any internal rule, protocol or criterion that was relied on in making the determination or indicate that a copy of such rule, protocol or criterion is available to you upon request; 9) if the determination was based on medical necessity, experimental treatment or other similar exclusion or limit, either explain the scientific or clinical judgment made or indicate that such a statement of explanation is available to you upon request; and 10) if your claim was an Urgent Care Claim, describe the Plan's expedited review process.

How do I appeal an adverse benefit determination?

To appeal an Adverse Benefit Determination, you must, within 180 days of receiving the determination, notify the Plan Administrator that you wish to appeal. You have the right to submit written comments, documents, records, and other pertinent information, and you will be

given reasonable access to, and copies of, all documents, records, and other information relevant to your claim. Send your written appeal to:

DMH Health Plan Appeals Committee
Decatur Memorial Hospital
2300 North Edward Street
Decatur, Illinois 62526
(217) 876-6111

The appeal will be conducted by the Plan Administrator as a named fiduciary, provided that the named fiduciary is neither the individual or a committee who made the initial Adverse Benefit Determination nor a subordinate of that individual or committee. This reviewer will not give deference to the initial benefit determination and will take into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination. If the Adverse Benefit Determination was based on a medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the medical field. This health care professional will not be an individual who was consulted in connection with the initial benefit determination or the subordinate of any such individual. Finally, the Plan Administrator will identify, upon request, any medical or vocational experts whose advice was sought in making the Adverse Benefit Determination.

The appeal of Urgent Care Claims can be conducted on an expedited basis. If you desire an expedited appeal, you must notify the Plan Administrator. This will allow the Plan Administrator to transmit all information to you by methods such as telephone and facsimile.

For Urgent Care Claims, the Plan Administrator will notify you of the benefit determination within 72 hours of your filing the appeal. For Pre-Service Claims, the Plan Administrator will notify you of the Plan's determination within 30 days of your filing the appeal. For Post-Service Claims, the Plan Administrator will notify you of the Plan's determination within 60 days of your filing the appeal.

What happens if my appeal is denied?

If the final decision on appeal is an Adverse Benefit Determination, the Plan Administrator will provide you with a notice that will: 1) be written in a manner that you understand; 2) include the specific reasons for the Adverse Benefit Determination; 3) refer to the Plan provisions on which the determination was based; 4) inform you that, upon request and free of charge, you are entitled to reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; 5) notify you of your right to bring legal action under Section 502(a) of ERISA; 6) include a copy of any internal rule, protocol or criterion that was relied on in making the determination, or indicate that a copy of such material is available free of charge upon request; 7) if the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either explain the scientific or clinical judgment made or indicate that such an explanation is available upon request and free of charge. Except as required by law, the decision is final and binding on all parties.

Should I use these administrative procedures before pursuing a claim in any other forum?

Yes. These appeals procedures are administered in the hope that most disputes can be resolved. You or your covered dependents must exhaust all the internal administrative remedies described above prior to bringing an action for benefits under the Plan under Section 502(a) of ERISA.

CONTINUATION OF COVERAGE

What is COBRA?

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), most employers that sponsor group health plans are required to offer covered employees and their covered family members the opportunity to temporarily extend health coverage under the employer-sponsored group health plan (“continuation coverage”) at no more than 102% of the group rate when certain events (“qualifying events”) occur that would otherwise cause such coverage to end. This Notice is intended to inform you of, in a summary fashion, your rights and obligations if you become a “qualified beneficiary” under COBRA’s continuation coverage provisions as applied to the Plan.

Who is eligible for COBRA?

Employees. You become a qualified beneficiary and you have the right to elect COBRA continuation coverage for yourself if you are an employee of Decatur Memorial Hospital who is covered under the Plan and you lose such coverage because of the termination of your employment (for reasons other than gross misconduct) or a reduction in your hours of employment.

Spouses. You become a qualified beneficiary and you have the right to elect COBRA continuation coverage for yourself if you are the covered spouse of an employee and you lose your coverage under the Plan for any of the following four reasons:

- (1) The death of your employee-spouse;
- (2) The termination of your employee-spouse’s employment (for reasons other than gross misconduct) or a reduction in his/her hours of employment with the Decatur Memorial Hospital;
- (3) Your divorce from your employee-spouse; or
- (4) Your employee-spouse’s entitlement to Medicare.

Dependent Child(ren). A dependent child becomes a qualified beneficiary and has the right to COBRA continuation coverage if he or she is a covered dependent child of an employee and he or she loses coverage under the Plan for any of the following five reasons:

- (1) The death of an employee-parent;
- (2) The termination of a parent’s employment (for reasons other than gross misconduct) or reduction in the parent’s hours of employment with the Decatur Memorial Hospital;
- (3) The parents’ divorce;
- (4) The parents’ entitlement to Medicare; or
- (5) The dependent child ceases to be a “dependent child” under the Plan.

Generally, the dependent child’s COBRA election is made by a parent on the dependent child’s behalf.

Who is responsible for notifications under COBRA?

Under COBRA, the employee or a family member is responsible for informing the Plan Administrator of a divorce, or a child losing dependent status under the Plan within 60 days of such qualifying event or the date on which the coverage would end under the Plan because of the qualifying event, whichever is later. The employer is responsible for notifying the Plan Administrator of the employee's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, spouses, and dependent children if the employer commences a bankruptcy proceeding and, as a result, individuals lose coverage under the Plan.

How do I elect COBRA and what coverage can I receive?

When the Plan Administrator is notified that one of these qualifying events has happened, the Plan Administrator will in turn notify you that you have the right to elect COBRA continuation coverage. Under COBRA, you have at least 60 days to inform the Plan Administrator that you want to elect COBRA continuation coverage. The 60-day period begins on the later of: (1) the date you would lose your group health coverage under the Plan because of one of the events described above, or (2) the date notice of your election rights is sent to you.

If you do not elect COBRA continuation coverage, your group health coverage under the Plan will end.

If you do elect COBRA continuation coverage, Decatur Memorial Hospital is required to allow you to elect coverage that is identical to the coverage you were receiving immediately before the qualifying event, to the extent such coverage for active employees has not changed. Also, you must be given the opportunity to maintain your COBRA continuation coverage for 36 months *unless* you lost your group health coverage because of the employee's termination of employment or reduction of hours. In the case of one of these latter two qualifying events, you must be allowed to maintain your COBRA continuation coverage for 18 months.

Under what circumstances is the 18-month period for COBRA coverage extended?

Under the following circumstances the 18-month period may be extended:

- (1) If an employee became entitled to Medicare (Part A or Part B) and within 18 months of such entitlement the employee's employment is terminated or his or her hours are reduced, then his or her covered family members will be afforded a total of not less than 36 months of COBRA continuation coverage (instead of 18 months) from the date of the employee became entitled to Medicare. Becoming entitled to Medicare means the employee is actually covered under Medicare.
- (2) After an 18-month period of COBRA continuation coverage begins, it may be extended to 36 months if the qualified beneficiary experiences certain other qualifying events (such as death, divorce, Medicare entitlement or ceasing to be a dependent child) during the 18-month period.

- (3) A qualified beneficiary's 18-month period may also be extended to 29 months if he or she is determined to have been disabled for Social Security disability benefit purposes during the first 60 days of COBRA continuation coverage, *provided* the qualified beneficiary notifies the Plan Administrator of this before the end of the initial 18-month period and within 60 days of such determination. However, you must also notify the Plan Administrator within 30 days of any final determination by Social Security that you are no longer disabled.

When will COBRA coverage end?

Your COBRA continuation coverage will expire at the end of your coverage period. In no event will COBRA continuation coverage last beyond 36 months from the date of the initial qualifying event. COBRA also provides that your COBRA continuation coverage may be terminated for any of the following five reasons:

- (1) Your employer and all of the members of its common control group no longer provide group health coverage to any of their employees;
- (2) You do not timely pay your COBRA continuation coverage premium;
- (3) You become covered by another group health plan after you have made your COBRA election that does not contain exclusions or limitations with respect to any pre-existing condition you may have (disregarding exclusions or limitations which do not apply because of the application of the creditable coverage rules);
- (4) You become entitled to Medicare (meaning you are actually covered under Medicare) after you have made your COBRA election; or
- (5) You extend coverage for up to 29 months due to your disability and, after the initial 18-month period expires, Social Security determines that you are no longer disabled.

Cost of Continuation Coverage and Payment

Your or your dependent's cost for continuation coverage is 102% of Decatur Memorial Hospital's cost for providing coverage to a similarly situated active employee. If you or your dependent is entitled to elect the additional 11 months of continuation coverage in the case of disability, the premium for the additional 11-month period will increase to 150% of the cost of providing coverage to a similarly situated active employee if the disabled member elects the extension. (If the disabled member does not elect the extension but other family members do, the applicable premium will remain at the 102% rate.)

The American Recovery and Reinvestment Act of 2009 reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with December 31, 2009. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage.

You and your covered dependents will receive written notice of the cost of continuation coverage at the time of eligibility. The cost will be adjusted from time to time, as costs for active employees are adjusted. You may request written verification of the cost of continuation coverage at any time during the continuation coverage period.

If you or your covered dependents elect COBRA, you will have 45 days from the date of your election to make your initial premium payment. That payment must cover the entire period from the time your active coverage would otherwise have terminated—you cannot elect to waive coverage for that period just because you did not need it. All continuation coverage payments will be made on an after-tax basis. After this initial 45-day grace period, your payment is due on the first day of every month and you or your covered dependents must pay the monthly premiums for the continuation coverage within 30 days of the payment due date. If your monthly payment for any month is not received within 30 days of the due date, continuation coverage will be terminated and you and your covered dependents will have no further rights to elect continuation coverage. Even if continuation coverage is elected, benefits for any period will not be paid until payment for that period has been made.

If I have any questions about COBRA, who should I contact?

If you have any questions about COBRA, please contact the DMH Human Resources Department. Also, if your marital status has changed or you or your spouse have changed addresses, please notify the Human Resources Department at Decatur Memorial Hospital, 2300 North Edward Street, Decatur, Illinois 62526, (217) 876-6111.

TERMINATION OF COVERAGE

When will my coverage under the Plan end?

Subject to the COBRA continuation option described in the section titled “Continuation of Coverage,” your coverage will end when you die, you cease to be an eligible employee, or you are terminated, whichever happens first. Also, if you request an option instead of this Plan under the DMH Flexible Benefits Plan, your coverage will end on the January 1 following your new election. (Or, if you make the election on January 1, your coverage will terminate that day.) And, if you fail to pay required contributions, your coverage will end on the last day of the period (15th or the end of the month) for which you did make contributions.

Your coverage will also terminate if the Plan is amended to eliminate your coverage, or if the Plan is terminated.

Do these rules apply also to my dependents?

Yes. Coverage for your dependents will terminate at the same time as your coverage in the situations described above.

SUBROGATION AND THIRD PARTY REIMBURSEMENT

What is subrogation?

Subrogation is the Plan's right to recovery of benefit payments made to you or to somebody else on your behalf when your illness or injury was caused due to an act or omission of a third party. Subrogation is the right of the Plan to "step into your shoes" and take action to recover benefits paid from the responsible party. The Plan is subrogated to all of your rights of recovery.

What is third party reimbursement?

When this Plan pays your medical benefits for a sickness or injury that was caused by an act or omission of a third party, the Plan has the right to be repaid for any medical benefits paid from any recovery, settlement, judgment or insurance proceeds you receive from (or on behalf of) that third party, organization or any insurer.

The Plan has a first-priority lien on any amount you recover from a third party, whether or not designated as payment for medical expenses, and including a right to any property to which the original recovery is converted. The Plan is granted this right of first reimbursement from all recoveries from a third party (whether by litigation, arbitration, settlement of a claim, or otherwise), however the recovery is designated (e.g., as payment for expenses). This right of recovery is primary, even if you are not made whole (i.e., compensated in full). The Plan's reimbursement rights apply to any benefits paid or payable by the Plan on your behalf as a result of any sickness or injury that was caused by an act or omission of a third party and to the Plan's expenses to enforce its rights under this section. This first-priority lien and right of reimbursement shall remain in effect until the Plan is repaid in full or until the claim is settled by the Plan fiduciary.

If you do not reimburse the Plan from any settlement, judgment, or insurance proceeds, or otherwise do not fully cooperate with the Plan's attempts to make a recovery, the Plan may reduce the amount payable to or on your behalf for current or future benefits until the Plan has been fully reimbursed. If you recover amounts from the third party that exceed the benefit payments already made by the Plan, the Plan may reduce its payment of future expenses for the applicable sickness or injury by the excess. In the event the Plan makes total payments that exceed the maximum amount to which you are entitled, the Plan shall have the right to recover the excess amount from persons to, or for, or with respect to whom, such excess payments were made, including, but not limited to, withholding payments otherwise available under the Plan. The Plan also reserves the right to bring legal action to obtain such reimbursement.

The Plan has a right to payment or reimbursement for any legal fees it expends in exercising its right to reimbursement.

If I have a claim against a third party for my sickness or injury, should I notify the Plan?

If you receive Plan benefits, you must immediately notify the Plan of the name of any third party against whom you might have a claim as a result of your sickness or injury (including any insurance company that provides coverage for you). For example, if you become injured in an

automobile accident, and the person who hit you was at fault, the person who hit you (and his insurance company) is the third party whose act or omission caused your illness or injury. You must cooperate with the Plan to obtain information regarding your illness or injury and you agree to sign any necessary documents for the Plan to subrogate your claim.

What can the Plan do when it asserts its right to subrogation?

The Plan may:

- place a lien against a third party to the extent benefits have been paid;
- may bring an action on its own behalf, or on your behalf, against the third party; and
- may cease paying benefits until you provide the Plan with the documents necessary for it to exercise its rights and privileges of subrogation.

What should I do if I receive a settlement, judgment or insurance proceeds because of a sickness or injury caused by a third party?

When our Plan pays your medical benefits for a sickness or injury that was caused by an act or omission of a third party, our Plan has the right to be repaid for any medical benefits from any settlement, judgment or insurance proceeds you receive from (or on behalf of) that third party. You must repay the Plan on a first dollar basis (meaning that the Plan has a right to be repaid first from any monies you receive). The Plan has a right to be reimbursed whether or not the third party admitted liability for the payment, whether or not a portion of the settlement, judgment or insurance proceeds was identified as a reimbursement of medical expenses, and whether or not you are made whole by the settlement, judgment or insurance proceeds.

You agree to provide the Plan with a lien, to the extent the Plan has paid medical benefits, to be filed with the responsible party or insurance company of the responsible party.

What if I am overpaid by the Plan?

If any benefit paid under the Plan should not have been paid or should have been paid in a lesser amount, the Plan Administrator reserves the right to request repayment immediately. The Plan has the right to pursue recovery for an overpayment of benefits from any amount you recover from a third party, including a right to any property to which the original recovery is converted. The Plan is granted this right of reimbursement from all recoveries from a third party (whether by litigation, arbitration, settlement of a claim, or otherwise), whether or not the recovery is designated as payment for benefits and even if you are not made whole (i.e., compensated in full). This right of reimbursement shall remain in effect until the Plan is repaid in full.

If you fail to repay the amount overpaid promptly upon demand, and/or you do not reimburse the Plan from any settlement, judgment, or insurance proceeds you receive, or otherwise do not fully cooperate with the Plan's attempts to make a recovery, the Plan may recover the overpaid amount by reducing the amount payable to you or on your behalf for current or future benefits until the Plan has been fully reimbursed. The Plan also reserves the right to bring legal action to obtain such reimbursement.

The Plan has a right to payment or reimbursement for any legal fees it expends in exercising its right or reimbursement. Also, the recovery rights of the Plan outlined in this provision will not be reduced to reflect your costs, including attorney fees, unless the Plan Administrator agrees, in writing, and in the exercise of the Plan Administrator's sole discretion.

IMPORTANT ADMINISTRATIVE INFORMATION

Name of Plan	DMH Health Plan
Type of Plan	The Plan is a welfare benefit plan maintained by DMH to provide health and welfare benefits for eligible employees and their eligible dependents.
Plan Sponsor	Decatur Memorial Hospital 2300 North Edward Street Decatur, Illinois 62526 (217) 876-6111
Plan Administrator and Agent for Service of Process	Plan Administrative Committee Decatur Memorial Hospital 2300 North Edward Street Decatur, Illinois 62526 (217) 876-6111
Employer Identification No.	37-0661199
Participating Employers	Decatur Memorial Hospital
Plan No.	506
Source of contributions	The plan is self-insured, which means that Decatur Memorial Hospital pays benefits out of its own funds.

The benefits under the plan are supported by the contributions of Decatur Memorial Hospital and plan participants, in accordance with the contribution requirements established by Decatur Memorial Hospital each year. Any contributions paid by a participant to Decatur Memorial Hospital, or withheld from a participant's wages, shall be remitted to the plan as soon as such contributions can reasonably be segregated from Decatur Memorial Hospital's general assets, but in any event within 90 days from the date Decatur Memorial Hospital receives such a payment or the date an amount withheld from wages would otherwise have been paid to the participant.

The amount of participant contributions required for each plan year shall be determined in advance by Decatur Memorial Hospital and communicated to participants. The amount of participant contributions remain set for the plan year and any additional premiums necessary to support benefits under the plan are paid by Decatur Memorial Hospital. Benefits under the plan are paid first from the aggregate contributions of participants, and Decatur Memorial Hospital pays the remaining cost of benefits provided under the plan.

Plan Fiscal Year, Plan Year	January 1 to December 31
Claims Administrator for the Participating Plan	Consociate Group 111 East Decatur Street P.O. Box 1068 Decatur, IL 62521 (217) 423-7788 or 1-800-798-2422 www.consociategroup.com
Pharmacy Administrator for the Participating Plan	Express Scripts Questions: 1-800-451-6245
Precertification/Utilization Review Administrator	American Health Holdings 1-866-345-3509

RIGHTS UNDER ERISA

What are My Rights Under ERISA?

As a Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the Plan, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called “fiduciaries,” have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide you the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.